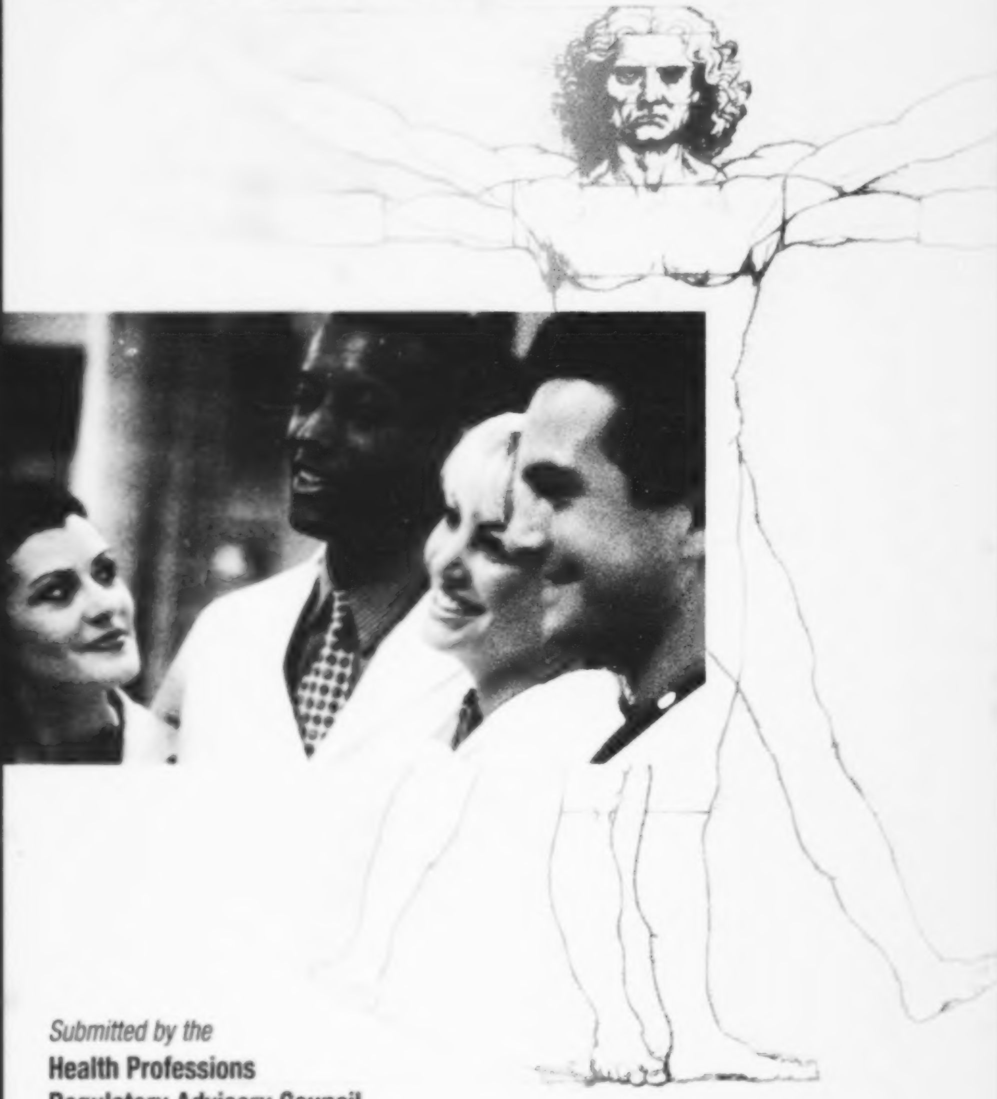
Regulation of Health Professions in Ontario:

New Directions

April 2006



A Report to the
Minister of Health and
Long-Term Care on
Regulatory Issues and
Matters respecting
Health Care
Practitioners,
Patients and Clients

Submitted by the
Health Professions
Regulatory Advisory Council
(HPRAC)

Ontario

Health Professions Regulatory Advisory Council

55 St. Clair Avenue West
Suite 806
Toronto ON M4V 2Y7
Tel (416) 326-1550
Fax (416) 326-1549

Conseil consultatif de réglementation des professions de la santé

55, avenue St. Clair Ouest
Bureau 806
Toronto ON M4V 2Y7
Tél (416) 326-1550
Téléc (416) 326-1549

Ontario

April 27, 2006

Hon. George Smitherman
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario M7A 2C4

Dear Minister,

The Health Professions Regulatory Advisory Council is pleased to submit to you its first report in response to your referral letter of February 7, 2005. Your request for advice was wide-ranging, and for us, invigorating. We believe that the recommendations contained in this report are foundations for sound public policy, backed by solid analysis and formulated with the involvement of hundreds of people. We want to articulate the sense of urgency with which we provide this advice to you – many of our recommendations respond to matters that have been outstanding for some time. Throughout, we have attempted to identify emerging challenges – not only in Ontario but around the world – that will bring fast-paced change while still demanding safety and quality in services and skills of our health professionals.

Health care is provided by people, for people. The way that people work together, the opportunity for people to work to the utmost of their knowledge and skills, the mechanisms that can assist people to work most effectively and that make the delivery of care by professionals more transparent and accountable are matters that we have reflected on, and that have helped shape our advice to you.

We look forward to working with you in the next phase of this important dialogue.

Yours truly,

Barbara Sullivan
Barbara Sullivan, Chair

Barry Brown
Barry Brown

Kevin Doyle
Kevin Doyle

Mary Mordue
Mary Mordue

Peter Sadlier-Brown

Ennis Fiddler
Ennis Fiddler

Regulation of Health Professions in Ontario:

New Directions

Page

1. Introduction 1
2. Legislative Framework 5
3. Regulation of Optometrists 115
4. Regulation of Pharmacy Technicians 127
5. Regulation of Homeopathy and Naturopathy 147
6. Regulation of Kinesiology 192
7. Regulation of Psychotherapy 206
8. Regulation of Personal Support Workers 229
9. Regulation of Hearing Care 249
10. Regulation of Opticians 278
Appendix A: Minister's Letter, February 7, 2005 293
Appendix B: Minister's Letter, June 16, 2005 297
Appendix C: Minister's Letter, January 18, 2006 299
Appendix D: Recommendations 301

INTRODUCTION

The Health Professions Regulatory Advisory Council (HPRAC) is submitting this report, ***Regulation of Health Professions in Ontario: New Directions*** to the Minister of Health and Long-Term Care following a year of extensive consultations with health professionals, associations, regulatory colleges and hundreds of individuals who have an interest in the extensive and direction-setting questions that the Minister put to HPRAC in February 2005.

HPRAC's advice has been strengthened markedly by the involvement of numerous individuals and organizations from across Ontario who contributed significant time and financial resources to make thoughtful contributions against tight deadlines for this ambitious undertaking. HPRAC is grateful for their expertise, experience and keen involvement in the debate and in the crafting of public policy options.

HPRAC estimates that close to 2,000 individuals and organizations participated in its work.

Urgency

The recommendations in this report will contribute to maintaining Ontario's cherished position as a leader in the regulation of health professions. They address matters affecting the efficiency, accountability, performance, quality and transparency of our health professionals and the Colleges that regulate them. Many issues on which HPRAC is now making recommendations have been outstanding for a number of years. Some now require urgent attention.

More than ever, health professionals must be able to adopt new technologies and changing methods of service delivery, while incorporating advanced knowledge into their practices. HPRAC's recommendations take into account the need to facilitate both professional and systemic progress. They acknowledge that people in Ontario want to be certain that they are receiving the best and safest care from the most qualified, up-to-date professionals. And they confirm that the regulators need the appropriate tools to do their work efficiently.

The way Ontarians view health care has changed dramatically in recent years. Many more people are focussed on wellness, and they are considering alternate and complementary approaches to the care they receive. HPRAC's recommendations acknowledge the need to regulate emerging health professions, with the goal of providing Ontarians with access to alternative health services, while ensuring that those who provide such care are answerable for its efficacious delivery.

HPRAC Affirms Ontario's Health Professions Regulation System

HPRAC views Ontario's current health professions regulation system as the most appropriate vehicle for the self-governance of our health professions. *The Regulated Health Professions Act, 1991 (RHPA)* was far-sighted when it was introduced, and it remains a model that other jurisdictions seek to emulate. HPRAC's *New Directions* does not propose a new model of regulation; it sets out new directions within the current self-regulatory model.

Responding to the Minister's Letters

HPRAC's *New Directions* report is submitted to the Minister of Health and Long-Term Care in response to his letter of February 2005 (Appendix A). In approaching this mandate, HPRAC combined several inter-related questions into one major Legislative Framework project that is central to the Advisory Council's current advice. Analysis and recommendations respecting the legislative framework are presented in Chapter 2 of this report.

Other matters included in the Minister's request were examined individually. To ensure consistency, the implications of HPRAC's analyses and recommendations on these matters were integrated into advice provided for the overall legislative framework. Recommendations at the request of the Minister respecting the regulation of psychotherapy, optometrists, opticians, hearing care, naturopathy and homeopathy, kinesiology, pharmacy technicians, and personal support workers are presented in chapters 3 to 10 of this report.

HPRAC's Consultative Process

The Minister asked HPRAC for advice on many health regulatory issues. In response, HPRAC reviewed previous recommendations, examined practices, experiences and legislative provisions in other jurisdictions, conducted wide-ranging consultations through a variety of mechanisms, engaged in extensive analysis, and completed an in-depth clause-by-clause review of the *RHPA*.

The literature and jurisdictional reviews and consultations for all projects were undertaken during the period February 2005 to January 2006. These reviews enabled HPRAC to identify emerging issues, outstanding concerns, and regulatory interventions in other jurisdictions aimed at addressing similar matters. The jurisdictional reviews generally covered experiences in the Republic of Ireland, the United Kingdom, Australia, New Zealand and states and provinces in North America. Some of the projects entailed a review of initiatives in jurisdictions in Europe, India and South Africa. A review of jurisprudence, legal principles and precedents was carried out as appropriate.

HPRAC placed great importance on hearing the views and suggestions of the widest possible cross-section of interested Ontario individuals, colleges, associations and other groups in reaching its conclusions. To that end, the Advisory Council posted opportunities for stakeholder participation on its website. As well, letters inviting participation were sent to individuals and organizations throughout the province. HPRAC used a variety of methods to solicit information and expertise, including key informant interviews, telephone interviews, Internet surveys, individual meetings, workshops, focus groups, public hearings, circulation of discussion papers and written submissions. Presentations were made to a number of organizations. Advertisements for public hearings were placed in major daily newspapers in locations where the hearings were held, including Kingston, London, Ottawa, Thunder Bay, Sudbury, Hamilton and Toronto. Brochures inviting written submissions were made available at the public hearing sites and through various organizations and associations.

For the legislative framework project, HPRAC conducted telephone interviews with people from diverse groups, including new Canadians, seniors, individuals in rural and remote areas, youth, complainants, people with disabilities, women, people with many social, cultural and faith backgrounds and voluntary health associations. HPRAC held separate workshops in Toronto with the 21 health regulatory colleges, associations representing health professionals and public members of college councils. Public hearings, held in Toronto and Ottawa, provided additional information and genuinely helpful direction. HPRAC also received numerous written submissions.

For those projects relating to new professions under the *RHPA*, or for professions currently regulated under the *RHPA*, information was obtained through jurisdictional reviews, key informant interviews, workshops, focus groups, public hearings, presentations, discussion papers and written submissions.

Awareness of the Role of Regulatory Colleges

The primary duty of health self-regulatory colleges in Ontario is to protect the public interest. While colleges may be making significant strides in this direction, their existence, mandate, goals and achievements are not well-known to the public. As patients become more informed consumers of health care services and seek more accountability by health care professionals and health care institutions, the interaction between colleges and the public must be cultivated and communication activities expanded. This became clear to HPRAC throughout the preparation of this report.

Reconfiguring Existing Colleges, and Establishing New Ones

There are currently 21 health regulatory colleges under the *RHPA* governing 23 health professions. HPRAC's recommendations for the regulation of new professions will result in the reconfiguration of existing colleges and establishment of new stand-alone colleges. HPRAC anticipates that over the next few years there will additional requests for other health professions to be brought under the *RHPA*, or situations where it is advisable to do so. New models within the *RHPA* may be suitable in these circumstances, particularly if current provisions are not feasible or warranted, or where public confusion exists. This report identifies some options that can be considered in the future.

For several new professions for which regulation is being recommended, it will be necessary to establish transitional councils. Each new profession will have different challenges to address and, therefore, the transitional body for each new profession will have to be structured differently and assigned a different mandate and timeline. These issues are discussed in the specific chapters respecting these new professions.

HPRAC is firmly convinced that adopting the recommendations put forward in *New Directions* will keep Ontario focussed on the future of health care. The Advisory Council also recommends regular reviews of the *RHPA* and profession-specific Acts to ensure that Ontario's health professionals stay abreast of the changes that are taking place with breathtaking speed in all health care areas, and that regulatory colleges are able to work effectively and efficiently.

The intent of the *Regulated Health Professions Act* was that it would be "living legislation". Legislative consideration should occur as a matter of course, and not once every 15 or 20 years.

HPRAC submits that its recommendations are sound and will bear the test of time. For that reason, it urges the Minister to use his influence to invigorate the dialogue and examine HPRAC's recommendations with a view to early implementation.

LEGISLATIVE FRAMEWORK

Index

Page

The Questions ... 6

HPRAC's Approach to the Questions ... 6

1. Introduction ... 7

2. Changes Since 1991 ... 8

3. The College Structure and Processes ... 15

4. Transparency and Accountability ... 32

5. Complaints and Reports ... 35

6. The Harm Clause ... 53

7. Professional Titles ... 55

8. Regulation Approvals ... 62

9. Governance ... 71

10. Controlled Acts and Scopes of Practice ... 76

11. Health Human Resource Planning ... 76

12. Appeals and Review ... 81

13. Confidentiality Provisions ... 82

14. Shared Service Business Model ... 84

15. Emerging Issues ... 85

16. Moving Forward ... 93

17. Summary of Recommendations ... 93

LEGISLATIVE FRAMEWORK

The Questions

On February 7, 2005, the Minister of Health and Long-Term Care requested the Health Professions Regulatory Advisory Council (HPRAC) to provide advice to him on the following matters:

- The currency of, and any additions to, recommendations made by the Council as part of the "5 year review" of the [*Regulated Health Professions Act, 1991*] *(RHPA)* contained in its report *Adjusting the Balance*;
- The currency of, and any additions to, the Council's recommendations in relation to the colleges' quality assurance programs and patient relations programs;
- The currency of, and any additions to, the Council's recommendations in relation to colleges' complaints and discipline procedures;
- Whether there are any impediments in the *RHPA* or the profession specific acts to a shared services business model for new professions for whom the financial demands of regulation are onerous, but where the public interest would be served by regulation, e.g. joint annual payment processes between new colleges or new college with an existing college; and
- … Any new or emerging issues that HPRAC becomes aware of.

In a later letter, dated January 18, 2006, the Minister indicated that the new *Traditional Chinese Medicine Act, 2005* provides for the use of the "Doctor" title by certain members of the new College of Traditional Chinese Medicine Practitioners of Ontario. To assist in the formulation of this new certificate of registration, the Minister asked that HPRAC provide advice by September 30, 2006:

- regarding the educational requirements relating to "Doctor" title respecting certain members of the new College;
- what the new College Council should consider respecting educational requirements needed to achieve the "Doctor" title; and
- how the standards for these educational requirements should be set and measured.

HPRAC's Approach to the Minister's Questions

HPRAC decided to respond to the legislative framework questions posed in the February, 2005 letter of referral in a combined report. Matters raised in the Minister's questions are inter-related, and relate to the principles, structure and regulatory framework of the *Regulated Health Professions Act, 1991*, and of the Health Professions Procedural Code, which is Schedule 2 to the Act. The Advisory Council, has therefore developed a Legislative Framework report that encompasses matters raised by the Minister, problems with implementation of the Act, and identifies new matters requiring consideration.

One of these matters was the question of title protection, and whether the Act appropriately reflected current practice elsewhere in Canada and abroad. HPRAC's initial conclusions will inform the response to the Minister's questions regarding Traditional Chinese Medicine that will follow in a later report.

In developing recommendations to other questions posed in the Minister's February, 2005 letter related to new professions and scopes of practice, HPRAC found that there were implications and new issues for consideration in the Legislative Framework report. Recommendations are included in this section.

The Minister's referral comes at a time of fast-paced change in health care delivery. Significant changes have occurred since the *RHPA* was first introduced in Ontario in 1991, including a shift to multi-disciplinary and collaborative care. Facilitating this trend, through provisions in health professions regulation is essential. It is also vital that our professionals have the flexibility to provide treatment and patient care to the fullest extent of their qualifications and training, and that they are able to respond effectively to changes in technologies and to new methodologies. Further, colleges need the appropriate tools and flexibility to fulfil their responsibilities while also building public confidence in self-regulation.

Many Legislative Framework issues examined by HPRAC, such as college structure and processes, complaints resolution and regulations approvals processes have been outstanding for a number of years. They address matters affecting the efficiency, accountability, performance, quality and transparency of our health professionals and the colleges that regulate them. HPRAC has concluded that some of these now require urgent attention.

1. Introduction

The *Regulated Health Professions Act, 1991* provides a mechanism for self-regulation of the health professions and helps protect patients and the public by ensuring that practitioners meet agreed standards of practice and competence.

Professional self-regulation affects both practitioners' initial entry into a profession and their continuing development and competence to remain in practice. Regulation can also help healthcare professionals to be confident that regulated practitioners to whom they refer patients or clients are skilled and will provide an appropriate standard of care.

For patients, caregivers and the public, a modern statutory regulatory framework provides reassurance that a practitioner is not only suitably qualified, but also competent and up-to-date with developments in practice.

Public members are now fully involved in the work of health professional colleges in Ontario, thereby ensuring that the views of patients and the public are properly represented in the regulatory process.

The matters that concern a college under the *RHPA* include education, registration, complaints, discipline, continuing professional development and, in a small minority of cases, health and fitness to practise proceedings.

1.1 The *RHPA* Model

As it did in its 2001 advice to the Minister, the Health Professions Regulatory Advisory Council continues to support "two of the fundamental elements of the health professions regulatory system as set out in the *RHPA* – self-governance of the professions and the system of controlled acts".

Indeed, we have noted in our investigations that the Ontario *RHPA* is the base for legislation in several jurisdictions in Canada. It is also cited as an 'unrealized dream' in many United States jurisdictions that currently use a state licensed health disciplines model for regulation of the health professions.[1] HPRAC concurs that the *RHPA* legislation that was adopted by the Legislature in 1991 continues to be a model of choice.

However, much has changed since 1991. It is useful to review some examples of the nature and pace of change in the health care sector and professional activity since the introduction of the *RHPA*.

2. Changes Since 1991

2.1 Technological and Communications Change

Around the same time the Ontario Legislature was enacting the *RHPA* in 1991, Internet pioneer Tim Berners-Lee was launching the first site on what was to be the World Wide Web. It is just one of the technological revolutions that has changed the way health care is delivered, consumed and managed in the intervening years.

In health care, the use of electronic communications has influenced matters from health records to diagnostics to direct patient care, where a specialist in one geographic area can review images and documents, collaborate with other professionals or perform surgery on a patient hundreds of miles away, or in a different location in the same city.

Berners-Lee probably never contemplated the influence that he would have on subsequent generations, and the demands that would be made on health professionals as a result of his development of WWW. In today's world, however, significant numbers of patients of all ages investigate diseases and conditions, and their prevention, treatment and management through information provided through the World Wide Web.[2] Health care providers and patients both commented to HPRAC on the use of the Internet for health information.

---

[1] Interviews with representatives of the Council on Licensure, Enforcement and Regulation (CLEAR)

[2] HPRAC study of patient expectations, January 2005 (unpublished)

For professionals, patient use of the Internet can sometimes be frustrating, since information may be inaccurate, may not reflect practice guidelines and current information, and may promote specific products or therapies; on the other hand, the information may supplement that which the practitioner provides to a patient or client in a time-constricted environment, and assist the patient in decision-making or comprehension of the risks and benefits of possible courses of treatment. It may also aid in providing additional information concerning follow-up care that a patient can readily follow. Many consumers report using the Internet for self-care, whether to obtain health promotion or disease prevention information, or to obtain details about conditions affecting themselves or their family.

Patients also use the Internet to locate a practitioner, and to review the qualifications and professional record of a practitioner when that is possible, so they can be fully informed about who will provide their care, in addition to the care that is provided. Consumers told HPRAC that they would like to have more information available to them.

Rapid technological change has affected every area of health care delivery. New diagnostic technologies such as MRI enable practitioners to make an early identification of patient disease, illness or conditions and to develop an appropriate course of treatment. This has increased the demand for people qualified to operate this sophisticated equipment and interpret the results of examinations. The number of MRI examinations and scans has increased exponentially. In 2003-2004, the estimated number of MRI scans in Ontario was 276,448; by 2004-2005, it was more than 316,000, and is expected to increase to 393,193 in 2005-2006.[1]

The introduction of telelmedicine provides another example of the benefits of changing technologies for both research and for clinical practice.

2.2 Clinical Practice and Pharmacological Advances

Over the past 15 years, significant changes have occurred in clinical practice. Less invasive surgeries, day-surgery, ambulatory care and drug substitution for surgery has impacted the way health services are delivered and the training required for professionals.

This has brought major change to clinical practice and disease management in areas such as cardiac care, renal disease, and chronic pulmonary disease. Innovations in pharmacology have revolutionized treatments of diseases including HIV/AIDS, cancer, schizophrenia, and cardiac care. Together, new pharmaceutical interventions and clinical developments have altered the way professionals practice, and revolutionized courses of treatment. These rapid advancements in clinical and pharmaceutical care place enormous demands on professionals to keep pace, and to develop new competencies throughout their careers.

---

[1] Source: Ministry of Health and Long-Term Care, Ontario, February, 2005

2.3 Patient Involvement in Care

Over the past 15 years, patients have become increasingly involved in managing their own care. They are determined to be fully informed about options, risks and benefits of treatment for illness, disease or other conditions, to participate in the management of their own care, and to ensure that their decisions are respected. The *Consent to Treatment Act, 1992* and the revised *Health Care Consent Act 1996* placed new demands on health professionals for accountability to and communications with their patients or clients.

HPRAC applauds the recent publication of the Ontario Hospital Association that provides advice to patients about how to be involved in their health care and how to speak up with questions or concerns about care.[4] This document, entitled "Your Health Care: Be Involved" was released in early 2006, and was developed by the OHA's Patient Safety Support Service with support from the Ministry of Health and Long-Term Care. It is available in 14 languages to meet patient needs across the province.

2.4 Population and Professional Demographics

Demographic change adds a new dimension to the work of health professionals, and creates new needs for sound health human resources policy and planning. The elderly (aged sixty-five and older) population is growing at 1.7 per cent per year and life expectancies continue to rise. The overall population is increasing at 1.2 per cent to 1.3 per cent per year.

This large and aging population contributes to increased incidence of chronic diseases, and a greater need to care for people with a number of complex conditions. This is creating a demand for multi-skilled professionals with new competencies.

As Ontario's population ages, so do its health care professionals. Nineteen per cent of practicing MDs (4,100) are over sixty, and 11 per cent (2,300) are over sixty-five

An Ontario Medical Association study of Physician Resources released November 21, 2005[5] reports that while the province's population is aging and growing and needing more care, the physician workforce is shrinking.

An earlier study, *Bringing the Future into Focus: Projecting RN Retirement in Canada*[6] (1993), reported that, in Canada, nearly one-third of RNs in the workforce are aged fifty years or older, and will soon reach the typical retirement age of sixty-five years. Research also indicates that an increasing proportion of registered nurses are retiring early, many by age fifty-six.

---

[4] http://www.oha.com/Client/OHA/OHA_LP4W_LND_WebStation.nsf/page/Your+Health+Care+-+Be+Involved

[5] http://www.oma.org/Media/News/pr051121.asp

[6] Joint study of the Canadian Institute for Health Information and the Nursing Effectiveness, Utilization and Outcomes Research Unit, University of Toronto

In the area of pharmacology, the aging population is creating an increase in prescription volumes. Pharmacists are increasingly being relied upon to monitor drugs that have been switched to non-prescription status – a world-wide trend. The average age of pharmacists increased only slightly in Canada from thirty-nine to forty years of age between 1991 and 2001.

Across Canada in 2001, increasing numbers of health professional are female. For example, more than half of pharmacists (57 per cent) were female, with a steady increase in the number of female pharmacy graduates evidenced (1993 – 61 per cent; 1999 – 66 per cent). This change brings with it changing patterns of work.[7]

Overwhelmingly, the social trends of the last decade indicate the desire for health professionals to balance life and work. They are no longer satisfied with one-hundred-hour work weeks, and want to devote more time to family and other pursuits. These factors impact the need for new professionals.

While working, professionals also want to perform to their maximum potential, including employing new competencies in the scope of their work.

2.5 Care in Community Settings

Since the early 1990's health care delivery in Ontario has included a greater reliance on community-based care, due to reform of the long-term care sector, increased ambulatory care in hospitals, and closing and downsizing of hospitals and psychiatric institutions. Changes in practice have also made it possible for many health services that were previously provided in institutions to be delivered in community settings. The review of health human resources in community based care, prepared for the Federal/ Provincial/ Territorial Conference of Deputy Ministers[8] noted:

> Reform of the existing system of occupational regulation is a sine qua non for developing and implementing a health human resources policy that supports community-based health care. This is particularly important because statutory regulation of health occupations is usually taken for granted and is seldom seen as an important policy tool for health system reform. Without changes to the way health occupations are regulated, it would be difficult to practise human resources substitution or use multiskilled workers. If community-based health care means becoming more responsive to the needs of the consumers, it is necessary to have a more flexible workforce. This, in turn, requires an occupational regulatory system that allows experimentation and innovative approaches in human resources utilization, development and management…
>
> ... Also, it is important to emphasize that reform of occupational regulation does not mean doing away with standards and safeguards. The challenge is to find alternatives to the present system, which enhance flexibility, appropriate use of human resources, consumer choice and quality assurance.

---

[7] Environmental Scan for the Provincial Health HR Strategic Advisory Group; Ontario Hospital Association, 2004

[8] Raymond W. Pong, Ph.D., Duncan Saunders, M.B., Ph.D., John Church, Ph.D., Margaret Wanke, M.H.S.A. , Paul Cappon, M.D., Ph.D. Prepared for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health through the Advisory Committee on Health Human Resources 1995

2.6 Alternate and Complementary Medicine

One aspect of demographic change in Ontario has been the arrival numbers of both consumers and practitioners of alternate and complementary medicine from countries where these approaches are accepted parts of the health delivery system. Together with other changes in attitudes, for many, the use of alternate and complementary medicine is the choice of patients. This was recognized most recently in Ontario with the introduction of *An Act respecting the regulation of the profession of Traditional Chinese Medicine Act* on December 7, 2005 and is supported by evidence of increase in the use of alternate and natural health products.

For both the regulation of health professionals and planning for care for people who are new to Canada, it is instructive to review data relating to immigration to Ontario. During the three-year period 2002-2004, Ontario received an average of 126,148 newcomers a year. This represents 55.2% of all newcomers landed in Canada.[9] 27% of Ontario's population is foreign-born, and 44% of Toronto's population is foreign born. People come from about 169 countries and speak over 300 languages.[10]

For many of these people, the use of safe complementary or alternate care is part of their experience, cultural heritage and way of life, and a preferable method of treatment over conventional medicine. They do, however, expect that practitioners who are providing their care are qualified and meet the standards of practice of the alternate form of medicine. Like others, they reject a *caveat emptor* approach to their health care.

On January 1, 2004, under the Natural Health Products Directorate, the Natural Health Product Regulations came into effect. Previously, natural health products were classified as either foods or drugs under the *Food and Drugs Act and Regulations*, as there was no separate category under which they could be classified. The regulations include provisions for definitions, product licensing, site licensing, good manufacturing practices, clinical trials, and labelling and packaging requirements.

The growth in self-care has also increased the market for natural products. ACNielsen Market Track ™ reports sales of herbal remedies through drug stores and food stores with pharmacies increasing from $75.7 million in 1998 to $77.5 million in 1999.[11] The most pronounced increases in national sales volumes in the period were for Echinacea (from $13.3 million to $19.5 million) and Ginko Biloba (from $ 6.8 million to $ 9.1 million).

This increase in the self-care market is another indicator of interest in alternative and complementary medicine, and raises concerns regarding the qualifications of those who offer alternative and complementary health services.

---

[9] Citizenship and Immigration Canada, Landed Immigrant Data System, 2005

[10] Statistics Canada, Census Data, 2001

[11] Information on the self-care industry has been adapted from Nonprescription Drug Manufacturers Association of Canada (NDMAC)

2.7 Multidisciplinary and Collaborative Care

Ontario's health professionals, researchers and public administrators are constantly developing innovative ways to improve the delivery of health care in Ontario. They are confronting the challenges of an aging population, hospital restructuring, rising incidence of chronic conditions, and more complex care requirements for patients in the community with new approaches and new ideas. One example is the increasing number of integrated teams of health providers. The team providing care may include physicians, nurses, physiotherapists, nutritionists, psychologists, pharmacists, respiratory therapists, occupational therapists and other professionals. When teams work together and coordinate care delivery, the patient's access to care can be substantially improved and the quality and comprehensiveness of patient care can be enhanced.

Educational programs are only now starting to focus on multidisciplinary and collaborative practice in order to prepare professionals for these new roles. There is still some distance to go. Training programs need to further emphasize the inter-relationship between professionals in providing patient care, and their joint responsibility for the quality of care delivered.

Inter-professional and collaborative care are particularly important for effective treatment of patients with chronic disease. For conditions such as congestive heart failure, coronary artery disease and diabetes, a combination of enhanced screening, monitoring, and education, improved coordination of care among providers, and the use of best medical practices, conditions and treatment options are identified more quickly, thereby slowing the progression of the disease.[12]

HPRAC believes the health professions regulatory environment should be structured to encourage and support this kind of positive development and innovation in the delivery of health care in Ontario.

2.8 Accountability and Transparency

Demands for accountability and transparency permeate the world of health care services and delivery in 2006. The public expects its practitioners and the places in which they work to continuously improve quality, and to use the most-up-to-date methods of providing care. Further, the public expects to know about how quality is being improved through regular reporting.

At a personal level, patients and clients expect a clear report on their health status from the professional providing care, so they can participate in decision-making. They also expect that the professionals providing care are continuously qualified and competent, and that if it is necessary to make a complaint, that they will be treated with dignity and respect.[13]

---

[12] *An Analysis of the Literature on Disease Management Programs*, Congressional Committee on the Budget, Oct. 13/04

[13] HPRAC Patient Expectations Survey, 2005

Governments are also demanding more accountability, including formal agreements with facilities and institutions indicating that certain benchmarks have been reached and targets met to ensure appropriate stewardship within the health care system.

For professionals, defined and enforced practice standards establish mechanisms for accountability and enhanced transparency, thereby building consumer trust.[14]

2.9 Global Influences

Around the world, healthcare costs have escalated, stimulated by medical advances and increasing demands. In the pharmaceutical sector, international companies seek to develop genetically targeted drugs and stem cell research, and many are moving clinical trials outside of Europe and North America.

International recruiting of nurses, physicians and other professionals has become a fact of life for many jurisdictions.[15] PriceWaterhouseCoopers has estimated that 250,000 nurses have left the Philippines for work in North America and Europe, sparking fears of a brain drain at home.

In Ontario in 2005, 39% of licenses to practice were issued to international medical graduates (IMG) by the College of Physicians and Surgeons of Ontario, compared to 27% in 1995. For the past two years, more certificates were issued to IMG's than to Ontario graduates. IMG's have received their medical education in 91 different countries.[16]

The College of Nurses of Ontario reports that Registered Nurse applications from internationally trained graduates have increased from 1,345 in 2000 to 1,942 in 2004. Registered Practical Nurse applications from international graduates have increased from 202 to 299 in the same period.

International accreditation agencies provide credentialing services to regulatory bodies and accreditation of educational institutions around the world. Labour mobility agreements between provinces and professional agreements throughout North America have the effect of increasing common credentialing criteria and transferable standards for professionals beyond borders.

2.10 Influence of Change on HPRAC's Deliberations

While HPRAC has considered matters on which the Minister requested advice respecting the *Regulated Health Professions Act*, and in its review of previous reports, it had to keep in mind the pace and extent of changes that had occurred in society and the health environment over the past generation. HPRAC hopes that advice provided to the Minister in this report reflects today's reality and prepares for the continuing influence of change on the events of tomorrow. These matters affect the efficiency and effectiveness of the Act and its regulations, and point to new needs in professional regulation. Thus, HPRAC was mindful of the trends noted in this section, in addition to others, in its deliberations, and they have influenced the Advisory Council's conclusions and the advice that is being offered.

---

[14] *HealthCast 2020: Creating a Sustainable Future*, PriceWaterhouseCoopers, February, 2006

[15] ibid.

[16] College of Physicians and Surgeons of Ontario, February 1, 2006

3. The College Structure and Processes

3.1 Committee Structure and Responsibilities

The Health Professions Procedural Code currently defines the objects of regulated health colleges in Ontario, entailing extensive obligations of the colleges to the public and members of the profession:[17]

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.

2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.

3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.

4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing competence among the members.

5. To develop, establish and maintain standards of professional ethics for the members.

6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.

7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

8. Any other objects relating to human health care that the Council considers desirable.

The Code also specifies an over-riding duty of the college "to serve and protect the public interest".[18]

These are substantial requirements, and the colleges must be structured to guarantee consistent and effective pursuit and achievement of these goals.

---

[17] Health Professions Procedural Code, Schedule 2 to *Regulated Health Professions Act, 1991*, Sec. 3 (1)

[18] Health Professions Procedural Code, Schedule 2 to *Regulated Health Professions Act, 1991*, Sec. 3 (2)

Colleges must also be structured to be able to adapt to changing conditions. They must accommodate both large and small memberships. It is also important that College structures include mechanisms for coordination of activities, and that they incorporate formal procedures that are evident to the public and members of the profession.

The colleges are also adjudicative bodies, subject to the principles of administrative law. Therefore, the college configuration must provide distinct structures and processes to accommodate policy-making, investigations, fair hearings, decisions and appeals, and to ensure natural justice.

With the introduction of the *RHPA* in 1991, the organizational form of the colleges was statutorily defined by function and object, and followed fairly closely on models of other regulatory bodies. Each college is governed by a council (or board of directors). Council composition varies from college to college, and requirements for the composition of the council are set out in profession-specific Acts. These Acts prescribe the number of public appointees and elected members for the council, and in some cases include requirements for academic representation. Slightly less than 50 per cent of council members are public appointees.

3.2 Committee Structure and Responsibilities

Colleges are currently required to have seven committees[19], including Executive, Registration, Complaints, Discipline, Fitness to Practise, Quality Assurance and Patient Relations. The council of the college is authorized to appoint members of the committees, and committee responsibilities and the processes they are required to adopt are variously specified by legislation, regulation and by-law.

Following experience with the Act and response to its consultations on the five year review of the *RHPA*, in 2001 HPRAC recommended a) that changes be made to protect the public/professional mix on Council; and b) the streamlining of the college structure, with the merging of committees, and the elimination of one committee. Five years later, with no changes having been made to the 1991 Act, the Minister of Health and Long-Term Care requested HPRAC to review the previous recommendations.

Consultative Process

As part of this review, HPRAC devoted considerable time to examining responses to the previous recommendations. The Advisory Council then embarked on renewed consultations, and analyzed options for an effective organizational structure. Stakeholders, including colleges, associations, legal counsel and individuals made either formal submissions or informal contributions to HPRAC's deliberations, and participated in workshops, interviews and meetings. HPRAC assessed models, incentives and outcomes of various models, and reviewed other statutes and the common law.

---

[19] Health Professions Procedural Code, Schedule 2 to *Regulated Health Professions Act, 1991*, Sec. 10

Advice was also sought from colleges on whether problems stemmed from narrow interpretations of the Act or from inadequacies in legislative drafting. Professional associations were asked to comment on areas that should be improved.

Through these discussions, various structural barriers (both in the current law and in previous proposals for change) that work against the achievement of college goals, objects and duties were identified to HPRAC, and alternatives offered. Respondents were anxious to see structural changes that would facilitate the colleges' ability to meet their public interest duties. Participants felt that the structure and function of the committees as they are currently constituted contribute to inefficiencies, inadequate communications and an inability to adapt to change. This can lead to negative public perceptions about the work and processes of colleges.

Participants also told HPRAC that within a mandated structure, there should be adequate flexibility to meet new challenges and adapt to changing conditions. There was virtual unanimity that procedural fairness must be protected, and should not be impaired by structural change.

3.3 Structural Change

The requirement for committees is a statutory device to ensure that the functions assigned to the committees are carried out by the colleges. Mandates and procedures of the committees are specified in legislation. Given the adjudicative nature of some of the committees, they may need the authority of a statute to carry out their responsibilities. HPRAC found that there are inconsistencies among colleges in the way their committee functions are implemented, some warranted by the particular circumstances of the regulated profession; some apparently related to a lack of resources.

It was clear to HPRAC that, as a result of the prescribed committee structure in the Act, there are impediments and limitations, both organizational and functional, that impinge on effective internal operations, information flow, transparency to the public, and the ability of the colleges to discharge their duties. It was also obvious that any proposals for change must take into account the variety in size and resources of the twenty-one existing colleges, and any new colleges that may emerge. HPRAC is convinced that change should occur, and should be implemented in a timely way.

HPRAC reviewed a number of models, and processes within those models in the course of its analysis and reviewed the nature and extent of the barriers that exist within the current college structure.

The Advisory Council discussed mandating the processes and functions in the statute and leaving it to each college to determine the best organizational structure to deliver on the mandate and account for performance. This report recommends this approach for Outreach functions, which is now a mandated Patient Relations Committee. For the other functions, HPRAC concluded that mandated committees continue to be the best way to protect the public interest.

In the end, HPRAC recommends changes to the number and functions of statutory committees to simplify often complex processes, improve efficiency, enhance transparency, and lead to more timely solutions to issues as they arise. HPRAC recommends that committee structures be as follows:

Committee	Function
Executive	• Exercises powers of Council between Council meetings
Registration	• Reviews applications for registration referred by Registrar; • Directs Registrar to approve, reject, or impose terms, limitations, or conditions on certificate of registration; • Recommends requirements for registration; • Ensures registration due process provisions are met; • Monitors, evaluates and reports on Registration process and outcomes.
Inquiries, Complaints and Reports (ICR)	• Receives all member-specific complaints and reports; • Conducts initial investigations re inquiries, complaints and reports; • Conducts practice assessments; • Requests Registrar to appoint investigator, receives report; • Requests Registrar to appoint health assessor, receives report; • Facilitates informal resolution; approves settlements; • Disposes of inquiries, complaints and reports by dismissal, resolution or referral to Discipline Committee or Fitness to Practise Committee; • Accepts voluntary undertakings and may require members to undertake specified continuing education or remediation activities; • Makes interim suspension and practice limitation orders; • Provides information, status reports and decision to complainant, reporter and member; • Monitors, evaluates and reports on ICR process, compliance and outcomes.
Discipline	• Receives cases from ICR • Conducts hearings into allegations against members; • Considers questions of professional misconduct, incompetence or failure to meet standards of practice; • Makes finding; • Orders sanctions appropriate to decision, including conditions, limitations on registration, remediation, fines, or suspension from practice; • Directs remediation programs required in discipline decisions; • Monitors compliance with disciplinary decisions; • Conducts reinstatement hearings; • Monitors, evaluates and reports on Discipline process and outcomes.
Fitness to Practise	• Receives cases from ICR • Conducts hearings into allegations of incapacity of members; • Considers questions of physical or mental illness or dysfunction; • Makes finding; • Orders action taken regarding member's registration; • Conducts reinstatement hearings; • Monitors, evaluates and reports on FTP process, compliance and outcomes.
Quality	• Recommends, develops and implements professional continuing competence and quality improvement programs; • Performs competency assessments and peer practice reviews; • Develops and monitors remediation plans; • Develops and conducts or implements continuing education programs; • Develops and engages members in multi-disciplinary quality and patient safety programs; • Reports incompetence, incapacity or misconduct to ICR; • Monitors, evaluates and reports on competence requirements, process and outcomes.

Changes that are represented in this proposal are more significant than they appear at first glance.

3.4 The Executive Committee will make administrative decisions when Council is not in session, and these will be ratified by Council when it meets.

There is no change in this role overall. However, under the recommended new structure, the Executive Committee will no longer receive mandatory reports regarding the conduct or competence of a member, or reports concerning the capacity of a member to practise, or be the vehicle for requiring the Registrar to conduct an investigation or establish a Board of Inquiry.

These responsibilities will be transferred to the Inquiries, Complaints and Reports Committee for consolidation with the handling of complaints. The expected outcome of this change is to reduce steps in the process enabling the work of the college to proceed more efficiently. Under the existing structure, these matters are dealt with in several places, with constraints on information exchange and delays in processing as a result.

3.5 The Registration Committee role will be largely unchanged. It will receive all referrals from the Registrar when there are reasonable doubts that an applicant fulfills the requirements for registration, when terms, limitations or conditions are proposed for a license of an applicant, or when the Registrar proposes to refuse registration. The Committee will consider the application, and direct the Registrar to approve an applicant's registration, impose terms, limits or conditions on the applicant's registration, or refuse the applicant's registration.

A new provision will enable the Registrar to refer to the Registration Committee if he or she has reasonable doubts that the applicant would practice the profession in accordance with the law, or with decency, integrity and honest. This provision is similar to that found in the *Gaming Control Act* and the *Racing Commission Act*.

3.6 The Inquiries, Complaints and Reports Committee (ICR), which replaces the Complaints Committee, will embody a new, simplified, more transparent and timely approach to inquiries and complaints that will be fair to both members and patients. The committee will receive all information, documents and reports concerning a member no matter what the originating source. Thus, if a patient, client or family member has a complaint about a member, if a facility or a member makes a mandatory report about a member, if a Coroner makes a report, or if a citizen makes an enquiry, they will be received and managed in one central place. Provisions for the constitution of panels of the ICR Committee will remain as they are currently stipulated in the Act for the Complaints Committee.

The new Committee will be charged with the initial investigation of the matter which will lead to one the following dispositions: a) dismissal of the matter, b) facilitation of a resolution, c) approval of informal resolutions, settlements or agreements, d) cautioning a member, e) disposal of the matter, including accepting undertakings or remediation, f) a request of the Registrar to appoint an Investigator, g) a referral to the Discipline

Committee, h) a request of the Registrar to appoint a health assessor, and i) a referral to the Fitness to Practise Committee.

The Committee's initial investigation will include obtaining statements from witnesses, copies of relevant documents, obtaining information from the Register and the full position of the source, complainant and member. The investigation of a complaint will include obtaining a patient's chart, a professional's billing information, approaching the member's colleagues, staff or other person, conducting a practice assessment, or other information gathering as appropriate.

If the committee cannot obtain adequate information and it believes there are reasonable and probable grounds that the member has committed an act of professional misconduct or is incompetent, the committee will directly request the Registrar to appoint an Investigator to examine the practice of the member. The results of the investigation will be reported to the ICR Committee for action, an appropriate disposition with written reasons for the decision. Similarly, in the case of questions relating to the incapacity of a member, the Committee will directly request the Registrar to appoint a health assessor to conduct an assessment of the member. The results of the health assessment will be reported to the ICR Committee for its action, including determining the appropriate disposition and providing written reasons. The Board of Inquiry will no longer exist because its powers and functions will now reside with the ICR Committee.

In certain exceptional circumstances, the committee will also have the power to order the Registrar to impose interim suspensions or practice limitations in respect of a member. This will happen at the same time as the matter is referred to the Discipline or Fitness to Practise Committees. This order could only be made in circumstances where the committee has reasonable and probable grounds to believe that the member's conduct exposes or is likely to expose the public to harm or injury, or when the member has refused to cooperate with a mental or physical assessment. The committee will be accountable for the due process requirements of the current Act which will continue to apply in these circumstances, including providing notice to the member along with all the information it relied on in making the order, and providing an opportunity for the member to respond and request a review. In the case of an interim suspension, the Discipline or Fitness to Practise Committees will be required to expedite their hearings into the matter.

The ICR Committee will no longer refer any remedies from its process to the Quality Committee (previously Quality Assurance Committee). The current provisions of the Act provide that following a referral of a complaint to quality assurance, decisions about a member's competence and any remediation that may have been ordered are not made public, or shared with complainants or other college committees. This confidentiality requirement, while serving to encourage participation of members in their college's quality assurance program, undermines transparency on complaint outcomes.

If an undertaking or other resolution is agreed to, the ICR committee itself will be responsible for overseeing the resolution and monitoring compliance.

This provision ensures that there is no misunderstanding amongst the public or members of the college regarding the role of the Quality Committee.

The ICR Committee will also be expected to discharge new communications duties. Members, complainants and others who have provided information to the committee will be provided with ongoing information regarding the status and disposition of the matter, including projected timelines for disposition along with reasons if those timelines are not met. This is discussed further in section 5 of this report.

Additionally, the ICR Committee will have the new responsibility of monitoring its performance, tracking data, preparing reports for the public and government and undertaking performance improvement activity.

3.7 The Discipline Committee will receive referrals from the Inquiries, Complaints and Reports Committee, conduct hearings as now required in the Act, and reach decisions accordingly. It will no longer receive referrals from the executive committee. It will have the power to find a member not guilty, or to find the member guilty and to impose appropriate sanctions. As with the ICR Committee, sanctions will no longer include direct referral to the Quality Committee (currently Quality Assurance). If the sanctions include remediation, additional training or similar courses of action, the Committee will be responsible for specifying the remediation required and monitoring compliance.

If compliance is wanting, the matter will be returned to the Discipline Committee for another hearing. If the sanction is removal from the register, the Discipline Committee will provide direction to the Registrar. The Committee will also conduct reinstatement hearings and provide direction to the Registrar subsequently. In the event that the ICR committee has made an order for the interim suspension of a member, the Discipline Committee will be required to proceed expeditiously with a hearing. Due process requirements of the current Act will continue to apply in these circumstances, and the member's right of appeal to Divisional Court will remain.

Additionally, the Committee will have the new responsibility of monitoring its performance, tracking data, and undertaking performance improvement activity.

3.8 The Fitness to Practise Committee will continue in its role. It will conduct in-camera hearings into allegations of incapacity against a member following a referral from the ICR Committee, and make a finding based on evidence presented at the hearing. The committee will continue to be responsible for ordering the Registrar to take appropriate action regarding the member's registration, including terms, conditions, limits or removal from the register when that is necessary.

The Fitness to Practise Committee will be responsible for monitoring compliance with an order. It will also conduct reinstatement hearings and provide direction to the Registrar accordingly. In the event that the ICR Committee has directed the Registrar to make an interim suspension of a member and referred the matter to the Fitness to Practise Committee, the committee will be required to proceed expeditiously with a hearing. Due process requirements of the current Act will continue to apply in these circumstances, and the member's right of appeal to Divisional Court will remain.

Additionally, the Fitness to Practise Committee will have new responsibilities to monitor its performance, tracking data, and undertake performance improvement activity.

In its 2001 report, HPRAC recommended that the Fitness to Practise and Discipline Committees be merged into one Professional Conduct committee. HPRAC has reviewed this recommendation with the benefit of input from individuals, colleges and associations, both supporting and opposing the previous recommendation.

To HPRAC today, it is clear that the discipline and fitness to practise processes should be distinct and separate, with different provisions for privacy protection and public transparency. The Fitness to Practise Committee deals with matters where allegations concerning the physical and mental health, dysfunctions and disorders of the member are exposed. Other health professionals may provide expert testimony about the physical or mental health of the member. In the course of the hearing, and until a decision of the Committee has been made, the member has the right to expect privacy concerning personal health matters, and therefore a closed hearing. If a decision is made by the committee that the member's practice should be restricted, or that the member should no longer be permitted to practise, the decision should be recorded on the public register. In the case of Discipline hearings, issues deal with professional misconduct and competence to practise. The public expects that the hearings will be transparent, and the process will be understandable, lawful, fair and expeditious. Discipline hearings will remain open to the public.

Therefore, HPRAC has concluded that a distinct Fitness to Practise Committee should be retained in a revised college committee structure.

3.9 The Quality Committee, formerly the Quality Assurance Committee, will be responsible for important matters relating to quality improvement and quality assurance in the profession and continuing competence of members. Its work will encompass education, training, and practice assessments, and it will facilitate cross-professional training and education for members. If the Committee had concerns respecting the conduct, competence or capacity of a member, it will make a report to the ICR committee. In general, however, the work of the Quality Committee will be confidential, comparable to the practice used in most quality improvement and patient safety programs.

Today's healthcare services are provided in a complex environment where even the simplest of procedures often require many steps and professional interaction. Hospitals across Canada have made substantial strides to develop patient safety programs based on inter-disciplinary root cause analysis of adverse events and near misses, and these are now a standard part of the Canadian Council on Health Services Accreditation (CCHSA) reviews. HPRAC is convinced that the principles of patient safety are readily transferable to the quality improvement programs of regulatory colleges to enhance professional competence and advance patient safety and quality of care within and across disciplines.

Separating Quality and Discipline Functions

For professionals involved in college quality improvement processes, whether peer practice assessments or continuing education, the culture surrounding their participation is vital. They must have the confidence that when changes are identified as necessary in their own practice, or in the practice of a health care team of which they are a part, that there is no link to the discipline process. Rather the link is to enhanced competence, continuing improvement and outcome evaluation. Not only are there benefits to the individual and the health care team, but new aggregated knowledge can be shared with other members of the profession.

For this reason, HPRAC is recommending that the quality improvement and quality assurance role in colleges be distinct and separate from the discipline process.

Reports to ICR Committee

In rare cases, matters may arise which cannot be kept within the bounds of the Quality Committee. If the Committee, as a result of a practice assessment, is of the opinion that a member may have committed an act of professional misconduct, may be incompetent or incapacitated, or if the member has refused to comply with the requirements of a quality program, the Committee will make a report to the ICR Committee concerning the member and the allegations. The ICR Committee will investigate and make a disposition in these circumstances.

Quality Assurance Programs

The Health Professions Procedural Code currently requires all colleges to have a quality assurance program that is overseen by the Quality Assurance Committee. The Code now specifies that the term quality assurance program "means a program to assure the quality of the practice of the profession and to promote continuing competence among the members". The Code leaves it to colleges to determine the appropriate elements and design of their quality assurance program.

To assist colleges in designing their quality assurance programs, the Ministry developed a guideline in 1996 entitled *Principles for Quality Assurance Programs and Regulations under the Regulated Health Professions Act, 1991*. It suggested three components for colleges' quality assurance programs. They are:

(i) To identify and address the issue of members who are incompetent or unfit to practice, or whose skills are deficient but can be improved through remedial activities.

(ii) To ensure the maintenance and improvement of individual member's competence (i.e., knowledge and skills remain current), over time;

(iii) To raise the collective performance of the profession, by focusing on patient outcomes and "what works best".

Colleges' quality assurance programs vary considerably. The lack of consistency across colleges, however, may provide colleges with an opportunity to develop evaluation capacity and to learn from each others' experiences.

The Federation of Health Regulatory Colleges of Ontario (FHRCO) established a Quality Assurance Working Group (QAWG) to train staff on evaluation approaches and to share best practices in evaluating quality assurance programs. QAWG meets regularly to share information on approaches to competency assessment, learn from invited experts, and jointly sponsor continuing education programs for their members. HPRAC sees this as a positive initiative.

Compliance with Quality Assurance Programs

The *RHPA* requires all members to comply with a college's quality assurance program requirements and cooperate with the college's assessors. Currently there is no enforcement power assigned to the Quality Assurance Committee for cases where compliance or cooperation is not forthcoming. The Quality Assurance Committee therefore refers such cases to the Executive Committee. Some colleges have asked that the powers of the Quality Assurance Committee be expanded to allow the Committee to impose restrictions on a member's certificate of registration until the member complies.

HPRAC considered three options in relation to this issue: (1) expand the powers of the Quality Committee to compel participation of non-compliant members, (2) enable the Quality Committee to refer members to the ICR Committee or (3) permit colleges to suspend a member's certificate of registration until the member complies and allow colleges to determine the appropriate due process for such suspensions.

HPRAC concluded that the Quality Committee should refer cases where the member does not comply with quality programs or cooperate with assessors to the ICR committee. The ICR committee will review the matter in the same manner as it would deal with a report from another source. The matter will then be disposed of by the ICR committee following its review or referred to the Discipline or Fitness to Practice Committees as appropriate. This provides increased options for both the college and the member, provides for consistency in processes and enhances transparency in the process.

Practice and Competency Assessments

Currently, the Complaints Committee may dispose of a complaint about a member by referring it to the Quality Assurance Committee, which may then include the member in its general competency assessment program and order remediation to address any detected deficits. HPRAC has concluded that practice assessments required to address complaints are substantively different from continuing competency assessments conducted for quality assurance purposes. In HPRAC's view, the public interest is best served by making a distinction between practice assessments used for complaints investigations, which should be managed in the ICR committee, and continuing competency assessments designed to improve professional practice, which should be the prerogative of the Quality Committee.

3.10 Multidisciplinary and Collaborative Practice

HPRAC has noted earlier in this report that multidisciplinary and collaborative practices are growing in importance

It is not surprising that the existing regulatory system did not contemplate the emerging trend toward multidisciplinary and collaborative practice. The challenges in the existing structure include issues such as those related to delegation of controlled acts, overlapping scopes of practice, information sharing, the need for colleges to collaborate on standards of practice for professionals involved in multidisciplinary teams, liability insurance and the handling of patient complaints, investigations and discipline.

While this appears to be a daunting list, HPRAC notes that a) there is a global trend towards multidisciplinary practice, b) patients appear to welcome the increase in access to care, c) many health professionals see working on health care teams as a way to improve the quality of their working life and to make the best use of their skills and training and d) there are potential benefits to the system in improving coordination and effectiveness in health care delivery.

HPRAC recommends that the procedural code be amended to give the colleges flexibility to deal with multidisciplinary practice and to send a signal encouraging colleges to cooperate and share information. Other specific recommendations include the introduction of a new objective for colleges: to promote interdisciplinary collaboration on matters such as common scopes of practice, joint investigations and quality programs.

3.11 Outreach Programs

HPRAC reviewed at some length whether the communications and outreach activities of colleges should be required as a statutory committee as provided in the current Act, or whether a culture of openness should permeate the entire organization.

HPRAC was surprised to learn how poorly the public understands the colleges' roles and responsibilities, and that by and large, people do not know how they can access information. Indeed, HPRAC was taken aback at some of the misconceptions held by people who work in the health care field regarding what colleges do and what they are required to do. People who visit the Ministry's website will find links to the home site of individual colleges, but general contextual information about regulation of health professions is absent.

Overall, HPRAC's sense is that the task of improving communications generally, by both the colleges and by the Ministry, fits perfectly with the government's new approach to stewardship and accountability in the health care system.

Some colleges expressed concern that additional responsibilities for communications and the provision of information would be costly. HPRAC notes that the FHRCO has taken some initial steps to enhance communications through joint sponsorship of advertising programs. This should be encouraged. Also, colleges could instigate shared programs with the Ministry, other colleges, or the Federation depending on the aims and outcomes expected of the program.

HPRAC's view is that one of the goals of self-regulation is to increase accountability. This can only be accomplished when the activities of the colleges are transparent and readily understood.

HPRAC concluded that there is a need for increased communications through all operations of all colleges, and that informational and outreach programs were best advanced, monitored and evaluated by the college council itself as a priority. Colleges should set annual goals for communication with members of the public, professional members and the Ministry, and ensure that they are carried out as an operational function that will be measured and evaluated.

HPRAC recommends that the statutory patient relations committee be disbanded, and the outreach program take its place.

HPRAC also suggests that patient relations functions relating to sexual abuse and funding programs for therapy and counselling for persons who, while patients, were sexually abused by members should likewise be managed in the most administratively effective place in each college. In the current statute[30], the Patient Relations Committee is charged with reporting to Council on a patient relations program that

- includes measures for preventing or dealing with sexual abuse of patients, including educational requirements for members, guidelines for the conduct of members with their patients, training for the college's staff, provision of information to the public, and
- administering the funding program for therapy and counselling for persons who, while patients, were sexually abused by members.

For many colleges, it may be most appropriate that the Quality Committee includes sexual abuse prevention, education and sensitization programs as part of its mandate, while for others, the most appropriate place for these programs is elsewhere in a college's operations. A suitable location for the administration of funding programs for therapy and counselling should be determined by individual colleges according to their own internal structures and processes. These matters, HPRAC is convinced, are best determined by the colleges, and should not be determined by rigid legal structures.

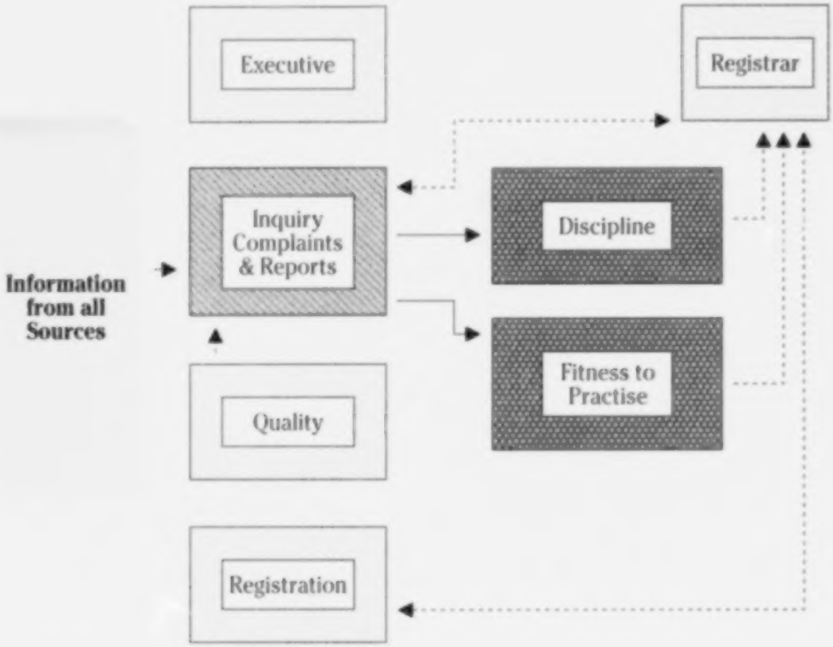
---

[30] Section 84, Schedule 2, Health Professions Procedural Code

To HPRAC, an appropriate mandate regarding public outreach is to develop and implement programs that provide clear information to assist individuals – whether patients or members - to exercise their rights under the *RHPA* and the Code, and to ensure that continuing communications are enhanced between the College and its members, other Colleges, the Minister and members of the public.

3.12 Goals: Efficiency, Access to information and Timeliness

HPRAC's recommendations relating to statutory committees are expected to foster increased efficiency in the administration of statutory requirements, provide for more complete access to information within a college structure, and increase the timeliness of decision-making. Under HPRAC's proposals, the flow of information and activity will be streamlined as follows:



3.13 To give effect to this revised structure and its principles, HPRAC recommends:

1. That Section 1 (1) of Schedule 2, Health Professions Procedural Code, should be amended by adding the following definition:

> "public outreach program" means a program to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991* and to enhance relations between and among the College, other Colleges, members, complainants and the public

2. That Section 1 (1) of Schedule 2, Health Professions Procedural Code, should be amended by deleting the definition of "quality assurance program" and substituting the following definition:

   "quality assurance program" means a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members

3. That section (3) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

   Objects of College

   3. (1) The College has the following objects:

   1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.

   2. To develop, establish and maintain:

      (a) standards of qualification for persons to be issued certificates of registration,

      (b) programs and standards of practice to assure the quality of the practice of the profession,

      (c) standards of knowledge and skill, and programs to promote continuing evaluation, competence and improvement among the members and to address patient concerns and complaints, changes in practice environments, advances in technology, and other emerging issues,

      (d) standards of professional ethics for the members,

      (e) programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991.*

   3. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

   4. To promote interprofessional collaboration with other Colleges as it relates to matters affecting two or more health professions, including, without limiting the generality of this, in connection with anything relating to,

      (a) standards of qualification, knowledge and skill for the performance of similar or shared controlled acts,

      (b) programs and standards of practice to assure the quality of the performance of the similar or shared controlled acts,

(c) programs to promote continuous evaluation, competence and improvement in the performance of the similar or shared controlled acts, and to address patient concerns and complaints, changes in practice environments, advances in technology and other emerging issues, and

(d) joint investigations of regulated health professionals practicing in multidisciplinary environments.

5. Any other objects relating to human health care that the Council considers desirable.

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest.

4. That section 10. (1) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

10. (1) The College shall have the following committees:
    1. Executive Committee
    2. Registration Committee
    3. Inquiries, Complaints and Reports Committee
    4. Discipline Committee
    5. Fitness to Practise Committee
    6. Quality Committee

5. That section 11. (1) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Each committee named in subsection 10 (1) shall regularly monitor and evaluate their processes and outcomes and shall annually submit a report of its activities to the Council in the form that the Council specifies.

6. That section 11. (2) of Schedule 2, Health Professions Procedural Code should be repealed.

7. That section 15 (2) of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

has doubts, on reasonable grounds based on the applicant's past and present conduct, that the applicant will practice his or her health profession in accordance with the law, or with decency, integrity and honesty.

8. That section 80 of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

(2) The quality assurance program shall include the following components:

(a) entry to practise requirements,

(b) standards of practice

(c) continuing education and professional development to promote continuing competence among the members and to address changes in practice environments, clinical standards, advances in technology and other emerging issues,

(d) self, peer and practice assessments,

(e) monitoring of members' participation in, and compliance with, the quality assurance program,

(f) evaluation or monitoring of data respecting complaints and reports, assessment and remediation processes and competence requirements to promote systemic improvement,

(g) interprofessional collaboration concerning the provision of quality care, continuous improvement in care and patient safety, or any matter described in clauses (a) to (g) as it affects the performance of similar or shared controlled acts.

9. That Sections 83 (3) of Schedule 2, Health Professions Procedural Code, should be repealed and the following substituted:

Referrals to Inquiries, Complaints and Reports Committee

(3) If the Quality Committee is of the opinion, based on an assessment, that a member may have committed an act of professional misconduct or may be incompetent or incapacitated, the Committee may disclose the name of the member and allegations against the member to the Inquiries, Complaints and Reports Committee.

10. That Sections 83.1 of Schedule 2, Health Professions Procedural Code, should be amended by adding the following subsection:

(9) The Quality Committee may do any one or more of the following:

1. Require the member to participate in a specified continuing education or remediation program or a self, peer or practice assessment.

2. Monitor the member's progress in the specified program or assessment and reconsider the member's practice upon its completion.

3. Refer the member to the Inquiry, Complaints and Reports Committee for a failure to co-operate with the Quality Committee or any assessor it appoints or to participate in the quality assurance program or a specified program or assessment.

11. That Sections 84 and 85 of Schedule 2, Health Professions Procedural Code, should be repealed and the following substituted:

84. (1) The College shall have a public outreach program.

(2) The public outreach program shall include the following components:

(a) programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*,

(b) measures to enhance relations between and among the College, other Colleges, members, complainants and the public, including without limitation,

i. notices to complainants and members,

ii. employer and facility relations,

iii. media relations,

iv. public register, public hearings and Internet publications,

v. reports to the Minister and the Health Professions Regulatory Advisory Council,

vi. interprofessional collaboration with other Colleges,

(c) measures for preventing or dealing with sexual abuse of patients.

(3) The measures for preventing and dealing with sexual abuse of patients must include,

(a) educational requirements for members;

(b) guidelines for the conduct of members with their patients;

(c) training for the College's staff; and

(d) the provision of information to the public.

(4) The Council shall give the Health Professions Regulatory Advisory Council a written report describing the public outreach program and, when changes are made to the program, a written report describing the changes.

85. Each Committee of the College shall advise the Council with respect to the public outreach program.

12. That Section 85.7 (3) of Schedule 2, Health Professions Procedural Code, should be repealed.

13. That wherever the words "Complaints Committee" appear in the *RHPA* or in the Health Professions Procedural Code, they should be replaced by the words "Inquiries, Complaints and Reports Committee", and that wherever the words "Quality Assurance Committee" appear in the *RHPA* or in the Health Professions Procedural Code they should be replaced by the words "Quality Committee".

4.0 Transparency and Accountability

An overriding concern of HPRAC was that the colleges function in a way consistent with the transformation of the Ministry of Health and Long-Term Care. In particular, HPRAC notes the Ministry's shift to a stewardship role, its focus on health human resources planning, and an enhanced focus on accountability, and monitoring performance and outcomes. Regulated health professions are in many ways out in front of these proposed changes. For example, responsibility for the day to day management of the regulation of health professionals is the role of the colleges, enabling the Ministry to be effectively involved the oversight of the system (its stewardship role). The Ministry is also concerned with health human resource planning, and needs improved data to achieve this goal.

There are areas for improvement. Throughout this report, HPRAC has emphasized the need for clarity, transparency and accountability in professional health regulation. Patients, members, associations and the colleges themselves seem to agree that transparency is a key element of accountability, monitoring and improvement. Essentially, one has to be able to see what is being done to measure and improve it.

There are other aspects to transparency as well: ensuring that people have access to the information that they need, when they need it. Most colleges now have websites to describe their activities, report on discipline committee decisions and scheduled hearings, and some include a list of practitioners on the website as a matter of course. This could become an even more useful tool for people who want to locate a practitioner if the register was filtered by geographic region or specialized area of practice, a practice in several other jurisdictions. Some jurisdictions also record whether the practitioner is accepting new patients or clients as a service to the public.

Most colleges do not publish the entire public register on their website, and individuals are restricted to obtaining information from the public register to "normal business hours" as permitted by section 23 (3) of the Procedural Code, and "upon the payment of a reasonable charge, a copy of any information in the register the person may obtain", as permitted by section 26 (6) of the Code. While the Act suggests access to information, it is a notional access at best: it is very difficult for an individual who does not reside in the same geographic region as the college is located to truly have access to information he or she believes is important.

An important principle of the Act is that specific information relating to health professionals must be public information. HPRAC is of the view that in an electronic communications age, the dissemination of information should be according to contemporary communications standards and practice.

4.1 To further enhance public information about the role of colleges and their processes and programs, HPRAC recommends:

14. That section 6 of the *RHPA* should be repealed, and the following substituted:

> (1) Each College shall provide to the Minister, within the time and in the form that the Minister specifies, the plans, reports, financial statements, including audited financial statements, and information that the Minister requires for the purposes of administering this Act or for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning.
>
> (2) The Advisory Council shall report annually to the Minister on its activities and financial affairs.
>
> (3) Each College shall collect from its members, and each member shall provide to the College, the information required to provide the reports to the Minister under subsection (1) and the reports to the Advisory Council under section 11.
>
> (4) Each College shall publish on its website on the Internet general information including, but not limited to:
>
> (a) its role, responsibilities, programs and processes;
>
> (b) the scopes of practice of the health professions it governs;
>
> (c) the use of titles by its members;
>
> (d) what constitutes professional misconduct for its members;
>
> (e) how to access the public portion of the register;
>
> (f) any other general information that the Minister specifies.
>
> (5) Each College shall publish on its website on the Internet, within the time and in the form that the Minister specifies, its audited financial statements and general and statistical information on its,
>
> (a) registration reviews and hearings;
>
> (b) complaints reviews and hearings;
>
> (c) discipline hearings;
>
> (d) fitness to practise assessments;
>
> (e) quality assurance assessments;
>
> (f) other programs and processes that the Minister specifies.

15. That Section 23 (3) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    (3) A person may obtain, during normal business hours and on the College's website, the following information contained in the register:

    1. Information described in clauses (2) (a), (b), (c), (d.1) and (d.2).

    2. Information described in clause (2) (d) relating to a suspension that is in effect.

    2.1 Information described in clause (2) (d.3) relating to a revocation or suspension that is in effect.

    3. The results of every disciplinary and incapacity proceeding,

        i. in which a member's certificate of registration was revoked or suspended or had terms, conditions or limitations imposed on it, or

        ii. in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the register by a panel of the Discipline or Fitness to Practise Committee.

    3.1 For every disciplinary proceeding, completed at any time before the time the register was prepared or last updated, in which a member was found to have committed sexual abuse, as defined in clause 1 (3) (a) or (b), the results of the proceeding.

    3.2 Information described in clause (2) (e.1) related to appeals of findings of the Discipline Committee.

    4. Information designated as public in the by-laws.

16. That Section 23 (6) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    (6) The Registrar shall provide to a person, upon the payment of a reasonable charge, a paper or electronic copy of any information in the register a person may obtain.

17. That Section 56 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    Publication of Decisions

    (1) The College shall publish a panel's decision and its reasons, or a summary of its reasons, on its website as soon as the decision is released and in its annual report and may publish the decision and reasons or summary in any other publication of the College.

5.0 Complaints and Reports

5.1 The Complaints Process

People who spoke to HPRAC about the complaints process, including patients, colleges, or professionals, spoke frankly about deficiencies in the system. While there were some positive experiences described, there was not sufficient evidence that the complaints process was working as well as it should. Both practitioners and patients suggested that there were some fundamental systemic issues that need to be addressed.

The reasons for the dissatisfaction varied. Some people were dissatisfied that they were not informed of the progress of their complaint, or how it was resolved. Some were dissatisfied with the disposition of the complaint, feeling it was either too lenient or that there was no satisfactory resolution. Some complainants said that they believed that when a matter was referred to the Quality Assurance committee, where activities are confidential, the college was protecting the member.

Members and professional associations, on the other hand, expressed concern that colleges were biased toward complainants. Some noted that the complaints process is designed to provide recourse for patients who have a complaint but not personal redress, which is a matter for the courts. The complaints process is fundamentally designed to achieve improvement in the practice of a member or of the profession.

There were conflicting responses regarding adequacy of communications regarding complaints, and this reflected differences among colleges in their administration of the process. Some felt that there was inadequate communication from the college to the patient or member regarding the complaint, while others noted that the college regularly communicated the progress at each step.

HPRAC acknowledges areas for improvement noted by complainants, including:

- Colleges should follow up with complainants to let them know exactly how the matter was proceeding or resolved, and

- The complaints process is too long: from lodging a complaint to resolution, it can "drag on for years".

Colleges themselves recognized problems in the system. HPRAC was told on numerous occasions that it was impossible to ensure the disposition of a complaint within the current 120 day statutory requirement. Indeed, the College of Physicians and Surgeons of Ontario advises on its website[21] that the disposition of a complaint can take up to one year. Several colleges pointed out that a full and fair investigation of a complaint should not be undermined by an arbitrary time limit, and noted that information-gathering necessary for consideration by a complaints panel should be thorough and pertinent.

---

[21] College of Physicians and Surgeons of Ontario *Annual Report 2004* (pp.11-12) http://www.cpso.on.ca/publications/dialogue/0105/Annual%20Report%202004.pdf

Appeals to the Health Professions Appeal and Review Board (HBARB) based on the inability to meet the 120 day deadline were widely regarded as an additional obstacle to timely disposition of a complaint. Several respondents proposed that new monitoring requirements should be included in the Act to ensure that optimal timelines are met for the disposition of all complaints. Many colleges suggested that the statute should require colleges to make their best efforts to dispose of a complaint within 150 or 180 days.

Communications relating to complaints was seen as particularly problematic, with many instances reported by members and complainants of lack of information regarding the status of the complaint.

HPARB recommended changes to the statute to enable: a) the Complaints Committee to consider prior complaints history when addressing the disposition of an individual complaint, b) the College to make available to the Board prior complaints history (as part of the record of investigation and the documents and information considered by the Complaints Committee), where a review is sought, c) the Board to take into account prior complaints history when addressing the reasonableness of the Committee's decision, and d) the Board to take notice of other cases that it has or has had before it in respect to a specific member when addressing the reasonableness of the Committee's decision.

HPRAC reviewed matters impacting a satisfactory complaints process, including initiatives in other jurisdictions to resolve similar challenges.

Other Jurisdictions

Complaints systems vary. In Australia, New Zealand and Great Britain complaints are addressed by a centralized complaints handling system, with a focus on less formal complaint resolution, and the tracking of complaints in an attempt to make system-wide improvements. These systems are patient-centered and include patient advocates who help complainants, provide advice and work to resolve complaints informally.

Australia and New Zealand have introduced a co-regulatory system for health complaints. Each state and territory has its own Office of Health Care Complaints Commissioner (HCCC) or Ombudsman, which acts as a 'one-stop-shop' for complaints by all health care users. The HCCC's are independent statutory bodies established to help resolve complaints in a fair and unbiased manner, and to use the information to make systemic changes to improve the delivery of health care.

The U.K.'s centralized complaint system is similar to that of Australia and New Zealand, and requires that complainants must first attempt to resolve their issues directly with the organization or practitioner involved. Attempts to resolve the matter informally at the initial stages are emphasized, with the complaint only moving to more formal investigations if the complainant does not feel the complaint has been satisfactorily resolved. Additionally, the tracking of complaints is used to address systemic change to improve service delivery.

In British Columbia, the College of Registered Nurses of British Columbia uses Nursing Concerns Coordinators (similar to patient advocates) who help complainants, provide them with advice, and inform them of their options. The Association reports that 80 per cent of complaints can be resolved informally. Alberta allows for mediation to be the first step in dealing with a complaint against a professional, and if a settlement is unlikely or is not reached, the complaint is then dealt with through the formal complaints process.

These patient-centered systems result in high patient satisfaction. A strong emphasis is placed on informal conflict resolution, and there is less litigation as a result.

The U.S is more litigious and disparate in operation. Complaints processes in the U.S. vary from state to state, but generally, complaints must be filed in writing and accompanied by a medical records release form. Complainants are informed that their complaint has been received, and then may not be contacted again until the closing of the case unless further information is required during the course of an investigation. In many states, there appears to be less emphasis on informal resolution of a complaint, and little evidence that patient complaints data are used to make systemic improvements to the profession.

The U.S. model also provides advantages and disadvantages. Patients are often able to evaluate prospective providers through readily accessible Internet reports of his or her professional record. Many patients prefer to be less involved in the process after a complaint has been lodged. For the member, the U.S. model enables each profession to maintain autonomy and complete control over their respective complaints procedures; and the process is not slowed by the use of advocates.

Having reviewed a number of complaints models from other jurisdictions, HPRAC sought information and comment on the viability of, or need for, these models in Ontario. HPRAC also received responses on the continuity and extent of communication with complainants and members who are involved in the process, and tracking of data relating to the cause of the complaint for systemic improvement.

There was thoughtful consideration of the benefits or limitations of introducing a centralized complaints system for all regulated health professionals in Ontario. Some respondents advocated for the use of some aspects of such a system, while others were concerned that profession-specific issues would not be understood. Some proposed that a centralized system would be useful in attempting to resolve complaints informally, and if this were not possible, the complaint would then be sent directly to the college for disposition. Some saw value in a common 1-800 number where patients could receive information on how to make a complaint, and be directed to the appropriate college.

There was strong support amongst participants for increasing the patient focus in the complaints process, ensuring that complainants are kept informed of procedures at all stages of the complaints process.

HPRAC concluded that:

- Before major changes to the *RHPA* model for complaints process are considered, it is important to find ways to address current deficiencies in implementation. Modest changes in statutory requirements, plus changes in the culture of dealing with complaints should be tackled in the first instance, and evaluations undertaken. If additional progress, efficiency and service improvement are seen to be needed and can be accommodated through new processes such as a centralized complaint intake system for all professions, consultations between HPRAC and the colleges should be undertaken. Discussions should determine the best method for enhancing patient and member satisfaction, improving timelines for complaint disposition, and ensuring that individual college's responsibilities for discipline are maintained. Conclusions reached should then be tested through a broader consultation program involving members of the public, health care institutions, professional associations and others.

- The statutory timelines for disposition of a complaint are not reasonable, and need to be changed. While many suggested that the statute should not specify time limits, HPRAC concluded that colleges should be required to use their best efforts to dispose of a complaint within 150 days. This ensures that a benchmark for the expeditious disposition of a complaint continues, and colleges should measure and report on their performance in meeting the benchmark.

  HPRAC noted that colleges define the start and end time for complaint disposition differently. Some colleges calculate the timeline from the receipt of the written complaint to the provision of written notice of the decision; others calculate the timeline from the point where the complainant and the college agree on the content and issues to be addressed in the written decision. For clarity and consistency across colleges, HPRAC recommends that the start time should begin with the receipt of the written complaint, and it should end when the college has provided the complainant and the member involved with written notice of the decision.

- The rights of an HPARB review on timelines delays, rather than accelerates, the disposition of complaints. When an request for a review to HPARB is made, the college's own investigation ceases, and a new investigation can be undertaken by the Board following the receipt of full information relating to the complaint and the progress of the investigation from the college. The involvement of the Board in this instance does little to enhance public protection, and may interrupt the progress of investigation that is underway. Therefore, HPRAC concluded that there is little benefit to this review that is triggered by timelines, and it should be removed from the statute. However, other demands should be made on colleges to proceed in a timely manner, and to provide notices to the complainant and the respondent.

- An open and transparent process by which both the complainant and the member are provided with notice of delay, advising them of reasons and a revised timeframe for resolution is vital. HPRAC has concluded that a statutory requirement for providing information concerning the status of the complaint is required.

- Within the current statute, there is no provision for consideration of complaints regarding care in a multidisciplinary environment, or for joint college investigations of complaints. Given changes in practice environments, HPRAC has concluded that the statute should enable joint investigations between colleges, and the sharing of information between investigators appointed by more than one college.

- A panel considering a complaint should have access to all relevant records and documents, including matters recorded on the register. There is now no mechanism for considering a member's complaints or report history at the original investigations level. This information is relevant to the disposition of the complaint, and should be considered by the panel. HPRAC concludes that the register should contain a record of every complaint and report filed with the college and the disposition of the complaint and report.

- While some colleges use alternate or informal resolution to attempt to resolve a complaint initially, there is no permissive enabling language in the statute, and no requirements for publication of the resolution in certain circumstances. HPRAC notes that alternate resolution can resolve an issue expeditiously and find mutually acceptable solutions that are appropriate to the circumstances. This is further discussed in section 4.5 of this report.

- The current provision enabling a complaints panel to refer to the Quality Assurance Committee is inappropriate, since it implies that quality improvement is a punitive action. The role of the Quality Committee should be for education, continuing competence and systemic improvement in the profession, and to provide members with the opportunity to improve their practice. If a complaints panel requests a member's cooperation in signing an undertaking requiring adherence to standards or a form of remediation, the monitoring of compliance should rest with the ICR Committee.

- If an ICR panel cannot obtain adequate information in the investigation of a complaint or report, and it has reasonable and probable grounds to believe that the member has committed an act of professional misconduct or is incompetent, the ICR Committee should have the authority to directly request the Registrar to appoint an Investigator to enquire into and examine the practice of the member. The results of the investigation will be reported to the ICR Committee for its action, including determining the appropriate disposition and providing written reasons. Similarly, if an ICR panel has reasonable and probable grounds to believe that a member is incapacitated, it should directly request the Registrar to appoint a health assessor to conduct a physical, psychological or other examination of the member, and to receive the report from the assessor for its consideration.

- In its 2001 report, HPRAC recommended that complainants should have party status at discipline hearings. HPRAC reconsidered this proposal following analysis of responses from colleges, associations and other intervenors and a review of the common law. HPRAC now concludes that the Minister should not act on the previous recommendation. In HPRAC's view, such an approach could result in an unfair hearing, given that a member would face two adversaries: the college and the complainant. This proposal would alter the nature of discipline hearings, and provides little or no benefit in public interest protection. Complainants now have the right to apply for intervenor status under section 41.1 of the HPPC, and should be advised of that right by the college.

5.2 To give effect to these proposals regarding the complaints process, HPRAC recommends:

18. That Section 23 (2) of Schedule 2, the Health Professions Procedural Code should be amended by adding a new subsection as follows:

    a notation of every complaint and report filed with the College and the disposition of the complaint and report.

19. That section 25 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    Investigation of complaints and reports

    25. (1a) A complaint or report filed with the Inquiry, Complaints and Reports Committee regarding the conduct or actions of a member shall be investigated by College personnel at the direction of a panel selected by the chair of the Committee.

    (1b) The panel shall monitor the progress of the investigation, request additional information from the investigator when necessary, and consider the results of the investigation.

    (1c) Where a complaint or report concerns a service provided in a multidisciplinary environment, the investigator may conduct or participate in an investigation of the complaint or report together with one or more investigators from or appointed by other Colleges, and may share information with the other investigators for the purposes of the investigation.

20. That section 25 (2) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

(2) A panel shall be composed of at least three members of the Inquiries, Complaints and Reports Committee, at least one of whom shall be a person appointed by the Lieutenant Governor in Council.

21. That section 25 (4) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

(4) A complaint must be in writing or recorded on a tape, film disk or other medium before it can be considered by a panel.

22. That section 25 (5) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Notice to member

(5) The panel shall give the member who is the subject of a complaint or report immediate notice of the complaint or report and of the provisions of subsection 26 (1).

Notice to complainant or reporter

(6) The panel shall give the complainant or reporter who filed the complaint or report written notice of receipt of the complaint or report, a general explanation of the College's processes concerning the complaint or report and an expected date of disposition of the complaint or report.

23. That section 26 (2) of Schedule 2, the Health Professions Procedural Code be repealed and the following substituted:

Powers of panel

(2) A panel, after considering the results of an investigation of a complaint or report and the submissions of the member and after considering or making reasonable efforts to consider all records and documents it considers relevant to the complaint or report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or report.
2. Refer the member to the Fitness to Practise Committee for incapacity proceedings.
3. Require the member to appear before the panel to be cautioned.
4. Require the member to complete a specified continuing education or remediation program.
5. Require the member to undergo a physical, psychological, practice or other assessment.

6. Accept a voluntary undertaking of the member.

7. Facilitate and monitor the progress of any alternative resolution processes between the complainant and the member before referring an allegation to the Discipline Committee or a member to the Fitness to Practise Committee.

8. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws.

24. That section 26 (3) of Schedule 2, the Health Professions Procedural Code should be repealed.

25. That section 27 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Notice of decision

27. A panel shall give the complainant and the member who is the subject of the complaint,

(a) a copy of its decision;

(b) a copy of its reasons, if the panel decided to take no action with respect to a complaint or to do anything under paragraph 3, 4, 5, 6 or 8 of subsection 26 (2); and

(c) a notice advising the member and the complainant of any right to request a review they may have under subsection 29 (2).

26. That section 28 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

28. (1) A panel shall use its best efforts to dispose of a complaint within 150 days after the filing of the complaint in writing.

(2) If a panel has not disposed of a complaint within 150 days after the filing of the complaint, the panel shall provide the complainant and the member with written notice of and reasons for the delay in disposition, and an expected date of disposition.

(3) If a panel has not disposed of a complaint by the expected date of disposition described in subsection 28 (2), the panel shall provide the complainant and the member with written notice of the progress of the investigation of the complaint and the new expected date of disposition every thirty days until the complaint is disposed of.

27. That section 26 (1) (a) of the *RHPA* should be repealed.

28. That section 36 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

DISCIPLINE

Inquiries, Complaints and Reports Committee Referral

36. (1) The Inquiries, Complaints and Reports Committee may refer a specified allegation of a member's professional misconduct or incompetence to the Discipline Committee.

Allegations of sexual abuse

(2) In deciding whether or not to refer an allegation of the sexual abuse of a patient to the Discipline Committee, the Inquiries, Complaints and Reports Committee shall take into account any opinion, required under subsection 85.3 (5), as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future.

Idem

(3) The Inquiries, Complaints and Reports Committee shall refer a substantiated obligation of the sexual abuse of a patient of the kind described in subparagraph i, ii, iii or iv of paragraph 2 of subsection 51 (5) to the Discipline Committee.

29. That section 37 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Interim suspension

37. (1) The Inquiries, Complaints and Reports Committee may, subject to subsection (5), make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if,

(a) an allegation is referred to the Discipline Committee; and

(b) it is of the opinion that the conduct of the member exposes or is likely to expose his or her patients to harm or injury.

30. That section 37 (5) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Restrictions on orders

(5) No order shall be made under subsection (1) with respect to a member unless the member has been given,

(a) notice of the Inquiries, Complaints and Reports Committee's intention to make the order; and

(b) at least fourteen days to make written submissions to the Inquiries, Complaints and Reports Committee.

31. That section 57, Schedule 2, the Health Professions Procedural Code should be repealed.

32. That section 58 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Appointment of health assessor

58. (1) The Registrar may appoint one or more health assessors to determine whether a member is incapacitated if the Inquiries, Complaints and Reports Committee has received a written complaint or report about the member and has requested the Registrar to conduct a health assessment.

Notice to member

(2) The Inquiries, Complaints and Reports Committee shall give a member notice that it intends to request the appointment of a health assessor to inquire into whether the member is incapacitated before the Registrar makes the appointment.

33. That section 59 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Inquiries by health assessor

59. (1) A health assessor shall make inquiries the health assessor considers appropriate.

Physical or mental examinations

(2) If, after making inquiries, a health assessor has reasonable and probable grounds to believe that the member who is the subject of the assessment is incapacitated, the Inquiries, Complaints and Reports Committee may require the member to submit to physical or mental examinations conducted or ordered by a health professional specified by the health assessor and may, subject to section 63, make an order directing the Registrar to suspend the member's certificate of registration until he or she submits to the examinations.

34. That section 60 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Health assessor's report

60. A health assessor shall report to the Inquiries, Complaints and Reports Committee and shall give a copy of the report and a copy of any report on an examination required under subsection 59 (2) to the member who was the subject of the assessment.

35. That section 61 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Referral to Fitness to Practise Committee

61. After receiving the report of a health assessor, the Inquiries, Complaints and Reports Committee may refer the matter to the Fitness to Practise Committee.

36. That section 62 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Interim suspension

62. (1) The Inquiries, Complaints and Reports Committee may, subject to section 63, make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if,

(a) it has referred a matter involving the member to the Fitness to Practise Committee; and

(b) it is of the opinion that the physical or mental state of the member exposes or is likely to expose his or her patients to harm or injury.

Procedure following interim suspension

(2) If an order is made under subsection (1) by the Inquiries, Complaints and Reports Committee in relation to a matter referred to the Fitness to Practise Committee,

(a) the College shall prosecute the matter expeditiously; and

(b) the Fitness to Practise Committee shall give precedence to the matter.

Duration of order

(3) An order under subsection (1) continues in force until the matter is disposed of by a panel of the Fitness to Practise Committee.

37. That section 63 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Restrictions on orders

63. No order shall be made with respect to a member by the Inquiries, Complaints and Reports Committee under subsection 59 (2) or 62 (1) unless the member has been given,

(a) notice of the intention of the Committee to make the order;

(b) at least fourteen days to make written submissions to the Committee; and

(c) in the case of an order by the Committee under subsection 62 (1), a copy of the provisions of section 62.

38. That section 75 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Investigators

75. The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,

(a) the Inquiries, Complaints and Reports Committee has received a report from the Quality Committee with respect to the member and has requested the Registrar to conduct an investigation; or

(b) the Inquiries, Complaints and Reports Committee has received a written complaint or report about the member and has requested the Registrar to conduct an investigation

39. That section 79 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Report of investigation

79. The Registrar shall report the results of an investigation to the Inquiries, Complaints and Reports Committee.

5.3 Alternate Resolution

The complaints brought to colleges about individual members are wide-ranging in nature and seriousness. Some raise questions about billing practices. Others draw attention to substandard record keeping or conflicts of interest. Still others fault poor communication leading to misunderstood diagnoses and poor case management. Other complaints involve serious lapses in professional judgment resulting in improper treatments. Even more serious, are reports of physical or sexual abuse.

Trends in health professions regulation show an increasing reliance on informal mechanisms to resolve complaints. Informal resolution reduces the adversarial nature of the complaints process and often takes less time to reach a resolution. Informal resolution also has the potential to reduce the number of complaints being adjudicated, which can save money.

Several jurisdictions, notably Great Britain, Australia and New Zealand, emphasize the use of informal resolution as the first step in the complaints process. These countries are also frontrunners in tracking the disposition of complaints, including those that are resolved informally, in hopes of contributing to continuous system-wide improvements.

In its 2001 report, HPRAC observed that in Ontario "colleges use ADR differently and have different names for the process". HPRAC concluded at the time that the "categories of cases appropriate for ADR at the complaints stage should be articulated in the HPPC".

In 2006, HPRAC concurs with this recommendation.

The *RHPA* makes no reference to the circumstances in which an opportunity to resolve an issue without a formal hearing is reasonable, or what the accountability to the public should be when it is used.

Section 4 of the *Statutory Powers Procedures Act (SPPA)* gives regulators a general power to use alternative processes in hearings, however, these do not apply in the complaints process, in which no hearing takes place. The *SPPA* provides that all parties in a hearing must consent to participating in an alternative dispute resolution mechanism, which may include mediation, conciliation, negotiation or any other means of facilitating the resolution of issues in dispute. It also requires that procedural guidelines be in place to deal with the circumstances in which a settlement achieved by means of alternative resolution must be reviewed and approved by the tribunal.

Today, alternate resolution mechanisms used by colleges differ. Some colleges do not use alternate resolution to any extent. The Royal College of Dental Surgeons uses external mediators for resolution of complaints. The College of Nurses, on the other hand, uses an internal alternate resolution mechanism and does not regard complaints as disputes. Instead the College strives to make system improvements as part of its approach to complaints resolution. The website of the College of Pharmacy states:

> Most times, we are able to resolve a complaint by talking to the patient and by making the pharmacist involved aware of the situation. Often the patient's concerns can be addressed either by an explanation of pharmacy policies, or by discussions between all parties involved. If the problem cannot be resolved, the patient is then asked to put his or her complaint in writing.

The Advisory Council has determined that there should be a permissive clause in the *RHPA* enabling colleges to use alternate or informal resolution in complaints proceedings except for complaints about serious sexual abuse. HPRAC further concluded that a written record should be made of decisions or resolutions, including a record of the matters disclosed, and any settlement should be reviewed and approved by an ICR panel. Subsequent to that approval, the results of informal resolutions will be placed on the college register.

HPRAC believes that the statute should clearly describe the principles of the alternate resolution process so they are fully understood by both complainants and members who are involved in the process, and that the colleges should ensure that complainants and members are wholly informed about all matters relating to the process and alternatives available. Colleges should be sensitive to any potential imbalance of power that might exist between the parties. The principles should include:

- A person appointed to help resolve a matter by means of an alternate resolution process may be a member of the ICR committee or an independent person; however, a member of the ICR committee who is appointed shall not subsequently hear the matter if it comes before the ICR committee unless the parties consent;

- Informed and voluntary consent to the process;

- Full and frank disclosure of all matters;

- Written decisions, including a record of the matters disclosed;

- Approval of the settlement by a panel of the ICR committee;

- No notes or records kept by a person appointed to facilitate the resolution of a complaint are admissible in a civil proceeding.

If at any point in the process a settlement cannot be reached, the alternate resolution process will cease, and normal processes of the ICR Committee commence.

HPRAC sees merit in encouraging and facilitating the informal resolution of complaints. With appropriate safeguards in place, alternate resolution can respect the adjudicative process and produce results in the public interest.

5.4 HPRAC recommends the following additions regarding alternate resolution should be made to Schedule 2, Health Professions Procedural Code:

40. That a new definition of be alternate resolution be added to the Health Professions Procedural Code as follows:

    "alternate resolution process" includes mediation, conciliation, negotiation or any other means of facilitating the resolution of issues in dispute.

41. That a new section be added to the Health Professions Procedural Code as follows:

    Alternate Resolution

    1. A panel of the Inquiries, Complaints and Reports Committee may direct a complainant and the member who is the subject of the complaint to participate in an alternate resolution process for the purposes of resolving the complaint or an issue arising from the complaint, unless the complaint relates to an allegation that the member has committed sexual abuse of the kind described in subparagraph i, ii, iii, iv or v of paragraph 2 of subsection 51 (5).

    2. All settlements achieved by means of an alternate resolution process must be reviewed and approved by the panel.

3. If the panel approves of a settlement, it shall create a written record of the process conducted containing, at a minimum, a description of the settlement reached and the matters disclosed during the process, and shall place this record on the register maintained by the Registrar.

4. If a settlement cannot be reached using the alternate resolution process or if the Inquiries, Complaints and Reports Committee refuses to approve the settlement, the usual process of the Inquiries, Complaints and Reports Committee shall commence.

5. An alternate resolution process may only be used if,

    (a) the complainant and the member consent, on an informed and voluntary basis, to participate in the process,

    (b) the Inquiries, Complaints and Reports Committee has made written rules concerning use of the process [including rules on full and frank disclosure of all matters and comprehension by both the complainant and the member of the language used].

    (c) the rules provide that a person appointed to help resolve a matter by means of this process may be a member of the Inquiries, Complaints and Reports Committee or a person independent of the Committee; however, a member of the Committee who is so appointed shall not subsequently deal with the matter if it comes before the Committee unless the complainant and the member consent.

6. No person appointed to help resolve a matter by means of an alternate resolution process shall be compelled to give testimony or produce documents in a proceeding with respect to matters that come to his or her knowledge in the course of his or her assistance other than a proceeding under the *Regulated Health Professions Act*, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act.*

7. No record, document or thing prepared for or statement given concerning an alternate resolution process is admissible in a proceeding other than a proceeding under the *Regulated Health Professions Act*, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act.*

5.5 Mandatory Reports

The *RHPA* currently requires members of a profession and facilities to report to a college when they have reasonable grounds to believe that member has sexually abused a patient.[22] It also requires an employer, which might be a hospital, a long-term-care home, or a laboratory to make reports to a college as follows:

> 85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Registrar within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons.
>
> Same
>
> (2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Registrar within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act.
>
> Application
>
> (3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services.

Many who spoke to HPRAC felt strongly that mandatory reports should be broadened to include physical abuse, addictions or health conditions that impair a practitioner's work, continuing errors in practice or clinical misjudgement. Each of these was cited for the grave consequences they may exert on a patient's safety or quality of life. Proponents supported the expansion of mandatory reports by members and facilities to include situations where there are reasonable grounds to believe that the conduct of a member exposes or is likely to expose his or her patients to harm or injury, or where a patient is at immediate risk. A report filed on this basis has, as its goal, the intention of stopping harm or preventing further harm before it happens. The Advisory Council was impressed with the reason and intensity of proponents' arguments.

HPRAC notes that reporting of misconduct, incompetence or incapacity is fundamentally different from reporting of adverse events with a view to impact systemic change. The closeness of working relationships can provide added insight into situations that may lead to patient harm. Thus, it is important for these reports to be written, and that they describe in some detail why there is reason for the reporter's concern. HPRAC also wants to be certain that a person who makes a report in good faith is protected from reprisal by provisions in the Act. The legislation was examined carefully in this regard.

---

[22] Section 85.1, HPPC

HPRAC views sexual assault as a very serious matter for which there should be zero tolerance. However, the Advisory Council concluded that the obligation to report to a college should be extended to include matters of professional misconduct, incompetence or incapacity. Protection against actions or proceedings against a person who provides information in good faith to a college about one of its members should apply in these instances. HPRAC has determined that there are adequate provisions in the Act to ensure immunity for those who make a report.

5.6 HPRAC recommends the following regarding mandatory reports:

42. That section 85.1 of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

> A member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same of different College has sexually abused a patient or has committed an act of professional misconduct or may be incompetent or incapacitated.

43. That section 85.2 of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

> A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds, obtained in the course of practising the profession, to believe that a member who practises at the facility has sexually abused a patient or has committed an act of professional misconduct or may be incompetent or incapacitated.

44. That section 85.3 (1) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

> A report required under section 85.1, 85.2 or 85.5 must be filed in writing with the Inquiries, Complaints and Reports Committee of the College of the member who is the subject of the report.

45. That Section 85.3 (2) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

> Timing of report
>
> (1) A report required under section 85.1, 85.2 or 85.5 must be filed within thirty days after the obligation to report arises unless, in the case of a report of sexual abuse, the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients or, in other cases, the person

who is required to file the report has reasonable grounds to believe that the member is putting his or her patients at immediate risk of harm, in which case the report must be filed forthwith.

46. That Section 85.3 (3) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Contents of report

(3) The report must contain,

(a) the name of the person filing the report;

(b) the name of the member who is the subject of the report;

(c) an explanation of the alleged sexual abuse, act of professional misconduct, incompetence, incapacity or revocation, suspension or imposition of restrictions on privileges or employment.

(d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4).

47. That Section 85.5 of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Reporting by employers, etc.

85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges or employment of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Inquiries, Complaints and Reports Committee within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons.

Same

(2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Inquiries, Complaints and Reports Committee within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act.

Application

(3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services.

48. That Section 85.6 of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

Co-operation with Inquiries, Complaints and Reports Committee

85.6 (b) Every person who files a report under section 85.1, 85.2, 85.4 or 85.5, and every person who may have relevant information about the member who is the subject of the report shall co-operate with the Inquiries, Complaints and Reports Committee and with any investigator it appoints and in particular shall,

(a) permit the investigator to enter and inspect the premises where the member practices;

(b) permit the investigator to inspect the member's records of the care of patients;

(c) give the Committee or the investigator the information in respect of the care of patients or in respect of the member's records of the care of patients the Committee or investigator requests in the form the Committee or investigator specifies; and

(d) confer with the Committee or the investigator if requested to do so by the Committee.

6.0 The Harm Clause

The *RHPA* harm clause (Section 30) prohibits individuals, other than regulated health professionals acting within their scope of practice, from treating or advising someone about their health in circumstances where it is reasonably foreseeable that serious physical harm may result. The effect of the harm clause is to prohibit either lay persons or professionals acting outside their scope of practice from performing potentially harmful activities related to a person's physical health.

The inclusion of the harm clause in the legislation created a great deal of debate.

The Health Professions Legislative Review concluded that a harm clause was necessary, and it was included in the first version of the legislation that was introduced in 1990. This legislation did not go forward.

> In commenting on the review's licence acts model, a number of participants expressed concern that licensing a series of acts identified

> as posing significant risk might of itself be insufficient to protect the public from harm. There are several reasons for this. The list, however carefully written, might inadvertently omit hazardous activity. The legislation might not keep pace with the development of hazardous new technologies that do not fit into one of the listed categories. Harm might be done by unscrupulous, unregulated practitioners providing care that avoids transgressing any particular licensed act. This section is aimed at preventing harm resulting from treatment or advice provided by persons who are not members of regulated health professions or who, if they are, exceed their scope of practice or licensed acts.[23]

When the current *RHPA* was later introduced to the Legislature in April, 1991, there was no harm clause written into the bill. Through the course of debate and committee review, many maintained that the harm clause was needed to cover the eventuality that the new list of controlled acts might not cover all of the hazardous activities that might be engaged in by unregulated practitioners or by regulated practitioners performing outside of their scopes of practice.

For these reasons, the government accepted an amendment to the bill that reintroduced the harm clause. Nonetheless, the harm clause refers only to physical harm, and does not recognize psychological or emotional harm. Nor was there a controlled act that spoke directly to psychological care. This has been raised as a deficiency numerous times since 1991, since it appeared that only physical health was protected in the basket clause, and mental health was excluded. This approach was taken in deference to concerns raised during these discussions indicating that courts would have difficulty interpreting psychological or emotional harm, making the provision unenforceable.

In 2001, HPRAC recommended that the harm clause be amended to add the element of psychological harm, and argued that "counselling about emotional matters can be harmful".

As a part of the consideration of the Minister's questions regarding the regulation of psychotherapy in 2005, HPRAC reviewed whether a change to the harm clause would provide greater protection to the public, and concluded that mental health should be considered alongside physical health as part of the health of an individual. Because this matter had to be considered in the context of the RHPA, HPRAC investigated whether there was more appropriate language to reflect the risk of harm to mental as well as physical health that could be expected to be upheld by the courts.

An examination of current Ontario law indicated that the phrase "serious bodily harm" is used in a number of provincial statutes, including:

---

[23] Schwartz, Alan M., Co-ordinator, Health Professions Legislation Review *Striking a New Balance: a blueprint for the regulation of Ontario's Health professions*, 1986

- *Child and Family Services Act;*
- *Education Act;*
- *Health Care Consent Act;*
- *Health Insurance Act;*
- *Mental Health Act;*
- *Ministry of Correctional Services Act;*
- *Patient Restraints Minimization Act;*
- *Personal Health Information Protection Act;*
- *Quality of Care Information Protection Act;*
- *Substitute Decisions Act.*

The Supreme Court of Canada, in the leading case concerning the interpretation of the phrase, found that "serious bodily harm" means:

> any hurt or injury, whether physical or psychological, that interferes in a grave or substantial way with the physical or psychological integrity, health or well-being of a complainant.[21]

This case is relevant to other statutes that use the same phrase, and has been used as a precedent in numerous cases. HPRAC believes that the principles expressed in the Court's decision are relevant to the *RHPA*, and can assist to provide a more robust description of the harm that may result to a person by an unregulated practitioner or a professional acting outside of his or her scope of practice.

6.1 Relating to the Harm Clause, HPRAC recommends:

49. That section 1 of the *RHPA* should be amended by adding the following definition:

    > "bodily harm" means any harm, hurt or injury, whether physical, psychological or emotional, that interferes in a substantial way with the integrity, health or well-being of an individual;

50. That section 30 (1) of the *RHPA* should be repealed and the following substituted:

    > No person, other than a member treating or advising within the scope of practice of his or her health profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably forseeable that serious bodily harm may result from the treatment or advice or from an omission from them.

7.0 Professional Titles

7.1 The Doctor Title

Section 33 of the *RHPA* creates restrictions on the use of the title "doctor" by health professionals in Ontario:

---

[21] R.v.McCraw [1991] 3 S.C.R. 72

33. (1) Except as allowed in the regulations under this Act, no person shall use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals.

Idem

(2) Subsection (1) does not apply to a person who is a member of,

(a) the College of Chiropractors of Ontario;

(b) the College of Optometrists of Ontario;

(c) the College of Physicians and Surgeons of Ontario;

(d) the College of Psychologists of Ontario; or

(e) the Royal College of Dental Surgeons of Ontario.

Definition

(3) In this section,

"abbreviation" includes an abbreviation of a variation.

This restriction is somewhat relieved by provisions in Section 43 (1) (d) of the Act, which enables the Minister, subject to the approval of the Lieutenant Governor in Council, to make regulations "allowing the use of the title "doctor", a variation or abbreviation or an equivalent in another language". This section has not been used since the *RHPA* was proclaimed.

> Despite this, many professions do use the title "doctor" based on historical usage, or because it is commonly and/or legally used in other jurisdictions.[25]

Other than convention, there does not seem to have been an underlying principle regarding the restriction on the use of the doctor title in the legislation. Arguments have been presented from time to time that allowing other regulated health professionals to use the title might lead to public confusion. There have also been concerns expressed that a person who had an earned degree in an unrelated field (such as Doctor of Engineering or Doctor of Musicology) might use the title "doctor" while providing health care.

The *RHPA* provisions continued the previous tradition of the *Health Disciplines Act* that prohibited anyone other than a dentist, physician or optometrist from using the title "doctor" and added two new professions (psychology and chiropractic) entitled to use the designation, apparently based on what had become common usage in society.

---

[25] Paul Henderson, *Demystifying the Doctors*, Vitality Magazine, July, 2005

There is some consistency in the selection of these professions in that they require an undergraduate degree followed by a minimum of four years in a professional school or academic program and successful completion of licensing examinations. These five professions also are authorized to perform controlled acts and in particular are authorized to perform the controlled act of "communicating a diagnosis".

However, restrictions on the use of the title in Ontario are inconsistent. They permit the use of doctor title for one group of professionals holding doctoral level academic distinctions while denying all other professionals with comparable doctoral level achievements a similar privilege. For example, audiologists, speech language pathologists, nurses or pharmacists who hold doctoral degrees in those professions may not use the doctor title while providing health services.

The restriction on the use of the title "doctor" applies only when the professional offers or provides health care to individuals. It does not stop a person who is engaged in academic research or administrative work from using the title. Thus, an audiologist with doctoral level training could be called "Doctor" while teaching advanced audiologic programs or conducting research on the subject, but could not use the title when treating or advising a patient fifteen minutes later.

Many individuals and organizations urged HPRAC to review the issue of protected titles in the *RHPA* with a view to achieving consistency and fairness. The College of Pharmacists of Ontario submitted that pharmacists who are registered with the College and have obtained doctoral degrees in either pharmaceutical sciences (Ph.D.) or clinical pharmacy (Pharm.D.) should be permitted to use the titles "Doctor of Pharmacy" or "Doctor of Clinical Pharmacy" respectively in the course of providing health care. The holders of these degrees are frequently employed in senior clinical positions in Ontario hospitals and provide leadership in the profession as teachers, researchers and practitioners in the field of drug consultative services. Many audiologists and speech language pathologists spoke of the inequity that currently exists in the restriction of the doctor title. Some intervenors observed that gender neutrality was not a feature of the current law, in that people with advanced degrees in many female-dominated professions did not have equal rights to use their titles. The Ontario Physiotherapy Association stated:

> We believe it is past time for HPRAC or the government to articulate a reasonable rationale for authorizing professions to use the doctor title and to develop a consistent framework of enforcement across all professions. This is particularly important as HPRAC and the government considers the regulation of new professions, some of which lay claim to the doctor title.

There are several relevant trends that need to be taken into account in examining this issue. First, there are many professionals who combine clinical practice with clinical research; this is of key importance in ensuring that knowledge is transferred from the research laboratory into clinical care. Another is common practice in the broader use of the title in other Canadian provinces, in the United States, Australia, the United Kingdom and the rest of Europe in a number of professions. A third trend is the emergence of complementary and alternate medicine where the doctor title has traditionally been used in other jurisdictions.

HPRAC reviewed the use of the doctor designation in other jurisdictions, and discovered that Ontario is anomalous in the restrictions that it imposes. The overwhelming majority of English speaking health professional regulatory bodies permit the use of the doctor title, often with a proviso that the title must include the discipline within which the doctorate has been granted. Some jurisdictions dictate the font size of the discipline when using the doctor title and make it professional misconduct not to include the name of the discipline. In Canada, naturopaths, podiatrists ((Alberta, B.C., Manitoba) and doctors of Traditional Chinese Medicine (B.C.) are included among those professions permitted to use the doctor title.

In Alberta, a person who is qualified and registered by a professional college with an earned degree may use the title doctor and the initials Dr. in conjunction with the delivery of professional services according to the regulations. Members of the College of Naturopathic Doctors of Alberta, with appropriate qualifications as authorized by the regulations, may use the titles naturopathic doctor or doctor of naturopathic medicine, or the abbreviations N.D. or R.N.D. A nurse with an earned doctoral degree who is registered may use the title doctor and its abbreviation in the course of providing health care.

Like Alberta, British Columbia authorizes the use of the doctor title for a variety of regulated professionals through profession-specific legislation or regulation. A registrant under the naturopathic physicians regulation may use the title "doctor" or the abbreviation "Dr." but only as "Doctor of Naturopathic Medicine", "Dr. of Naturopathic Medicine", "Naturopathic Doctor" or "Naturopathic Dr.". Traditional Chinese Medicine practitioners who have completed five years of TCM education at a recognized institute are authorized to use the title Doctor of Traditional Chinese Medicine. A registered podiatrist who holds the academic qualification of Doctor of Podiatric Medicine, granted by an accredited school or college of podiatric may display or make use of the title "doctor" or the abbreviation "Dr.", but only as "Doctor of Podiatric Medicine", "Dr. of Podiatric Medicine", "Podiatric Doctor" or "Podiatric Dr.".

As in British Columbia and Alberta, Manitoba authorizes the use of the doctor title for a variety of regulated professions and requires that the title specifically identify the discipline in which the doctorate is held.

The U.S. state of Kentucky requires that a person practicing medicine, surgery, osteopathy, optometry, dentistry, podiatry, pharmacy, chiropractic, psychology or psychiatry, nursing, anesthesiology, physio or physical therapy "or any other profession or business having for its purpose the diagnosis, treatment, correction or cure of any human ailment, condition, disease, injury or infirmity" may use the title "Doctor" or "Dr.," if he or she has graduated and holds a doctoral degree from a school, college, university or institution authorized by its governing body to confer such degree. The state further provides that those who use the title "Doctor" or "Dr." in any letter, statement, card, prescription, sign, listing or other writing must affix suitable words or letters designating the particular doctor degree held by such person.

In New York licensed individuals who have earned a doctoral degree may use the title "doctor," provided they disclose the field in which they hold the doctorate. An earned doctorate is a doctoral degree conferred by a recognized college or university authorized to confer doctoral degrees in the state (or, for foreign schools, in the country) in which it is located. Licensees in the health professions may not use the title "doctor" when offering to perform professional services without indicating the profession in which the licensee holds the doctorate. For example, for an individual with a Ph.D. in Music who holds a license in speech-language pathology to use the title, "doctor," he or she must indicate that his or her doctorate is in music.

Texas requires that in using the title "doctor" as a trade or professional asset or on any manner of professional identification, including a sign, pamphlet, stationery, or letterhead, or as a part of a signature, a person must designate the authority under which the title is used or the college or honorary degree that gives rise to the use of the title.

West Virginia, while enabling broad use of the title "Doctor" or the abbreviation "Dr." requires that a practitioner, such as an acupuncturist, possesses an earned doctorate degree from an accredited, approved or authorized educational institution but must clearly explain to his or her patients, in writing and verbally, that he or she is not a physician licensed to practice medicine or surgery.

California provides that a registrant may use a title, initials, or other prefix or suffix indicating possession of a specific earned academic degree granted by an approved or accredited institution, provided that in conjunction with the use of such title, initials, prefix or suffix, the registrant clearly identifies the title and nature of the degree.

HPRAC has concluded that this question is a social issue, and not a health-related matter. International practice, emerging professions and practices that combine clinical and academic activities with research make the rigid title distinctions of the *RHPA* unworkable. Current provisions appear to be a vehicle for maintenance of status rather than of public protection.

Therefore, the Advisory Council favours allowing registered professionals with an earned academic doctoral degree to use the title "Doctor" in the course of providing health care provided that:

- the academic distinction must have been granted by an educational institution that is accredited or approved by a certifying body authorized by the regulatory college;

- the doctoral title must be in the field in which the person is registered;

- that the title and the nature of the degree and the discipline in which the doctorate is held is clearly identified.

7.2 HPRAC recommends the following with respect to the Doctor Title:

51. That Sections 33 and 43(1)(d) of the *RHPA* should be repealed, and the following

substituted:

> 33. (1) No person shall use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals.
>
> (2) Subsection (1) does not apply to a person who,
>
> (a) is a member of a College; and
>
> (b) holds an earned doctorate degree in the discipline in which the person is registered by the College.
>
> (3) In this section,
>
> "abbreviation" includes an abbreviation of a variation; and
>
> "earned doctorate degree" means a doctorate degree granted by an educational institution that is accredited or approved by a certifying body that is approved by the College.
>
> (4) No person shall, orally or in writing, use the title "doctor", a variation or abbreviation or an equivalent in another language, under subsection (2) without indicating the discipline in which the person holds the doctorate.

7.3 Nurse Practitioners

The College of Nurses of Ontario has requested that "nurse practitioner" be a protected title under the *Nursing Act, 1991*, and become the recognized designation for a registered nurse who holds an extended certificate of registration, and is authorized to perform additional controlled acts.

The term "nurse practitioner" is widely used in other jurisdictions, and well understood in Ontario. Indeed, most people are puzzled rather than enlightened by the phrase "extended class nurse" that is now the appellation.

7.4 HPRAC recommends with respect to nurse practitioners:

52. That section 11 (1) of the *Nursing Act, 1991* should be repealed and the following substituted:

> No person other than a member shall use the title "nurse", "registered nurse", "nurse practitioner" or "registered practical nurse", a variation or abbreviation or an equivalent in another language.

53. That section 11 (5) of the *Nursing Act, 1991* should be repealed and the following substituted:

> No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a nurse, registered nurse, nurse practitioner or practical nurse or in a specialty of nursing.

7.4 Psychological Associates

According to the Ontario Association of Psychological Associates (OAPA), the Ontario Board of Examiners in Psychology, the Ontario Association of Consultants, Counsellors, Psychometrists, and Psychotherapists, and the Ontario Psychological Association signed a Memorandum of Agreement in 1991, prior to the passage of the *RHPA*. The Agreement allowed those providers of psychology services with a Master's level degree to be registered in the College of Psychologists of Ontario with the title "psychological associate". The Agreement apparently also provided for later consideration of the use of the "psychologist" title by master's level graduates.

In its 2005 submission to HPRAC, the OAPA stated that both psychologists and psychological associates have the same scope of practice, professional standards, level of autonomy and areas of practice. Currently about 500 members (approximately 20 percent) of the College are designated as "psychological associates".

Submissions from College members holding master's level degrees told of the problems they have encountered as a result of the "psychological associates" designation. For example, insurers or disability support programs can refuse to cover the cost of care provided by a psychological associate when criteria of contracts or programs specify that the services must be delivered by a psychologist. School boards and community colleges speak of the "psychologists" who provide services to students when most psychological services in these settings, HPRAC was told, are provided by "psychological associates".

Resolving this situation is not as straightforward as it may seem. On one hand, conferring the psychologist title on psychological associates is unlikely to have a detrimental impact on the public. Psychologists who hold a Ph.D. are authorized under the *RHPA* to use the title "Doctor" in the course of providing health care. This distinction, and its relationship to academic credentials, is clear. On the other hand, HPRAC notes that the current situation exists as a result of a decision by the College following debate within the profession. Also, provisions related to the federal-provincial Mutual Recognition Agreement respecting labour mobility and practice in other jurisdictions would need to be taken into account in any recommendation.

In the time-frame for this report, HPRAC was unable to complete a full examination, including jurisdictional reviews and consultations on this particular title issue.

54. It is the intention of HPRAC to conduct a further review and consultations on the use of titles in the profession of psychology, with a view to presenting recommendations to the Minister by October, 2006.

8. Regulation Approvals

In the course of reviewing the *Regulated Health Professions Act, 1991, (RHPA)* and the "Adjusting the Balance" five-year review of the *RHPA*, the Health Professions Regulatory Advisory Council continued to be apprised of serious issues related to government examination and approval of regulations under profession-specific Acts.

8.1 The HPRAC Review of the Regulation Approval Process

The referral letter from the Minister of Health and Long-Term Care to HPRAC in February, 2005 requested HPRAC to revisit the recommendations of the Five Year Review, and to identify and provide advice on emerging issues. The 2001 Review referenced problems with timely approval of regulations, but made no recommendations.

As HPRAC received early responses from regulated health professional colleges, associations and the public commenting on the Five-Year Review, the issue of regulation approval continued to be identified as a serious concern. In deciding to examine the matter in greater depth, HPRAC asked colleges to summarize their experiences, including a description of proposed regulations and the policies each was to address, the impacts of the proposed regulations on professional practice and public interest, any alternative mechanisms to give the same effect as regulations, and the status of the regulations in the process. The Advisory Council also asked the Ministry specific questions concerning its approach to regulation approval, and the processes and guidelines that are used.

8.2 Regulations in Ontario's Self-Regulating Health Professions

Self-regulation in Ontario's health professions is a partnership in which government confers certain rights and responsibilities to a profession which has the demonstrated capabilities to administer them. The underlying premise is that self-regulation preserves the public interest in several ways: it enlists practitioners in setting enforceable standards for the professions, relies on their expertise to develop measures to protect the public on the verge of technological change or other advancements affecting the profession, delegates governing bodies to resolve complaints, and addresses other matters related to a member's abilities or conduct.

For its part, the government retains authority over professional decisions through the enactment, amendment or repeal of legislation, and through the review and approval, amendment or repeal of regulations under the statute that governs the profession.

The *RHPA* and the profession-specific Acts specify the framework for the regulation of health professionals and delegates authority to the colleges to develop regulations and by-laws for each profession. The Minister has the duty under the Act "to ensure that the health professions are regulated and co-ordinated in the public interest, that appropriate standards of practice are developed and maintained and that individuals have access to services provided by the health professions of their choice and that they are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board"[26].

The Minister also has the responsibility and authority to review regulations made by college councils, and submit them for the approval of the Lieutenant-Governor-in- Council. Matters that are subject to the Minister's review are at the heart of the accountability of health professionals and their governing bodies to the public. They include[27]:

(a) prescribing classes of certificates of registration and imposing terms, conditions and limitations on the certificates of registration of a class;

(b) respecting applications for certificates of registration or classes for them and the issuing, suspension, revocation and expiration of the certificates or classes of them;

(c) prescribing standards and qualifications for the issue of certificates of registration;

(d) prescribing certain registration requirements as non-exemptible requirements for the purposes of subsection 18 (3) and 22 (8);

(e) defining specialties in the profession, providing for certificates relating to those specialties, the qualifications for and suspension and revocation of those certificates and governing the use of prescribed terms, titles or designations by members indicating a specialization in the profession;

(f) requiring, for purposes associated with the registration of members, the successful completion of examinations as set, from time to time, by the College, other persons or associations of persons and providing for an appeal of the results of the examinations;

(g) governing or prohibiting the delegation by or to members of controlled acts set out in subsection 27 (2) of the *Regulated Health Professions Act, 1991*;

(h) requiring and providing for the inspection and examination of premises used in connection with the practice of the profession and of equipment, books, accounts, reports and records of members relating to their practices;

(i) prescribing what constitutes a conflict of interest in the practice of the profession and regulating or prohibiting the practice of the profession in cases in which there is a conflict of interest;

(j) defining professional misconduct

---

[26] *Regulated Health Professions Act, 1991*, Section 3

[27] *Regulated Health Professions Act, 1991*, Schedule 2, Health Professions Procedural Code, Section 95 (1)

(k) designating acts of professional misconduct that must be reported;

(l) respecting the promotion or advertising of the practice of the profession;

(m) respecting the reporting and publication of decisions of panels;

(n) prescribing the standards of practice of the profession and prohibiting members from acting beyond the scope of practice of the profession in the course of practising the profession;

(o) requiring members to keep prescribed records in respect of their practice;

(p) regulating or prohibiting the use of terms, titles and designations by members in respect of their practices;

(q) prescribing alternative requirements for eligibility for funding for therapy and counselling for patients who were sexually abused by a member of a profession;

(r) prescribing a quality assurance program; specifying information to be collected for the purpose of complying with a quality assurance program;

(s) respecting the giving of notice of meetings and hearings that are to be open to the public;

(t) providing for the exemption of any member from the regulations made by the Council;

(u) prescribing anything that is referred to in the health profession Act or the Code as being prescribed.

The *RHPA* also enables the Minister to require a college council to "make, amend or revoke a regulation under a health profession Act or the *Drug and Pharmacies Regulation Act*"[28] and if the Council does not comply within sixty days, the Lieutenant Governor in Council, on the Minister's recommendation, may do so.[29] Regulations respecting controlled acts and the delegation of a controlled act by and to a member are also required by the Act.[30]

8.3 Ministry Guidelines

In 1996, the Ministry developed goals and principles for Quality Assurance programs. These principles highlight the importance of maintaining and improving the skills and competence of individual members, as well as advocating measures to raise the collective performance of the profession by focusing on creating better patient outcomes.

---

[28] Section 5 (1) (c), *RHPA*

[29] Section 5 (3), *RHPA*

[30] Section 27 (3) and 28, *RHPA*

The Ministry's initial focus was on developing program standards for entry-to-practice, preferred practice guidelines, initial practice registration, continuing competence, peer assessment and remediation of behaviour or remarks of a sexual nature. These were then issued as minimum requirements for college's Quality Assurance programs, and were intended to be captured in college regulations.[31]

The next document to come from the Ministry was "Guidelines for Colleges for Submitting Regulation Proposals to the Ministry of Health and Long-Term Care". Distributed in February, 2001, it specifies:

> what information is required by the ministry in order for regulation proposals to be processed. In addition to the information outlined in the guidelines, the ministry requests that colleges include a three column chart outlining the current regulation and/or provisions, the proposed change and the rationale for that change, and the record of consultation with stakeholders including professional associations.[32]

On November 19, 2004, the Ministry provided colleges with policy guidelines relating to drafting advertising regulations, including criteria that colleges should consider during the drafting process. Each college would "be permitted to expand the requirements for advertising based on profession-specific need" but colleges were required to ensure that the reasons "for expanding the requirements are clear and in the public interest". The Ministry asked colleges to review any existing advertising regulations or other regulations, such as those relating to professional misconduct, to determine compliance with the new guidelines. With the release of the guidelines, the Ministry indicated that it would not process any previously submitted regulation proposals regarding advertising.

On July 18, 2005, the colleges received the Ministry's Guidelines on drafting Conflict of Interest Regulations. These outlined "minimum criteria colleges should consider when drafting or amending their conflict of interest regulations." The Ministry asked colleges to review any existing conflict of interest regulations or other regulations such as those relating to professional misconduct, to determine compliance with the new guidelines. Once again, with the release of new guidelines, the Ministry indicated that it would not process any previously submitted conflict of interest regulation proposals.

In July, 2004, the Ministry issued "Guidelines on Incorporation by Reference of Documents into College Regulations under Health Profession Legislation"[33]. This guideline sets parameters around a 1998 amendment to the *RHPA* which enabled standards of practice regulations to adopt, by reference, any code, standard or guideline, and require compliance by members of the profession with the code, standard or guideline.[34] The "rolling incorporation" provisions of the Act enabled standards of practice to be updated in a timely way and to reflect current practice.

---

[31] Harry Cummings Associates report to HPRAC, July 2000

[32] Letter to Chair of HPRAC from Joshua Tepper, ADM, HHRSD, MOHLTC, Dec. 19/05

[33] Attachment, Letter to Chair of HPRAC from Joshua Tepper, ADM, HHRSD, MOHLTC, Dec. 19/05

[34] *RHPA*, Schedule 2, Health Professions Procedural Code, Sec 95 (1) and (2)

The 2004 Ministry guideline limits its use stating that "incorporation by reference is not a preferred drafting technique" outside of "detailed matters of an administrative, technical, scientific or similar matter". The guideline also stipulates that the reference document must be of a fixed date. If the document is subsequently amended, the regulation would require amendment as well. Finally, the standard of practice to be incorporated into the regulation also required Ministry approval. In addressing the rolling incorporation provisions of the statute, the Ministry indicated that "in exceptional cases a regulation prescribing standards of practice of the profession may adopt an external document in a way that automatically adopts future changes that are made to the document". The use of rolling incorporation is limited to situations where the standard "has been made by a recognized expert body that is independent of the college".

8.4 The Approval Process for Regulations

The regulation-making authority granted to self-governing professions does not give a free hand. There are constraints imposed by the enabling act, government policy and agreements, the Charter of Rights and Freedoms and other directives. As described, the Minister is responsible for reviewing regulations made by college councils before they go forward for approval by the Lieutenant-Governor-in-Council.

Within government, the regulation-making process is complex, involving internal Ministry scrutiny, liaison with other Ministries where the regulation may have an impact, and formal legal drafting of the regulation. New or amended regulations must also satisfy the requirements of the *Regulations Act*. As per that Act, a standing committee of the Legislature may also review proposed regulations "with particular reference to the scope and method of the exercise of delegated legislative power without reference to the merits of the policy or objectives to be effected by the regulations or enabling statutes".

The Legislature's Standing Order 106(H) provides terms of reference for the Committee that serve as a general description of the requirements of regulations under a statute:

- Regulations should not contain provisions initiating new policy, but should be confined to details to give effect to the policy established by the statute.
- They should be in strict accord with the statute conferring of power, particularly concerning personal liberties.
- Regulations should be expressed in precise and unambiguous language.
- They should not have retrospective effect unless clearly authorized by statute, and should not exclude the jurisdiction of the courts.
- Fines, imprisonment or other penalties should not be imposed by regulation, and regulations should not shift the onus of proof of innocence to a person accused of an offence.

- As distinct from fixing the amount of a licensing fee or similar, a regulation should not impose anything in the way of a tax.

- General powers should not be used to establish a judicial or administrative tribunal.

Finally, the *Regulations Act* requires publication of every regulation in *The Ontario Gazette* within one month of its filing. Publication has significant legal implications. In particular, s. 5(3) of the *Regulations Act* states that a regulation which is not published "is not effective against a person who has not had actual notice of it."

8.5 Ministry Relations with Colleges:

The majority of health regulatory colleges reported some frustration in dealing with the Ministry on regulations submitted for review and approval. The Ministry also noted concerns with the process and referred to specific problems with regulations as submitted.

The College Perspective

Some colleges reported that they have been advised that the Ministry has no record of their regulation proposal. The following are examples of college concerns:

- The College of Dental Hygienists of Ontario reported that it submitted an amendment to its professional conduct regulation in July, 2002 and was advised in 2004 that the Ministry had no record of the proposal. The College indicated that it resubmitted the regulation in August, 2004, and received an acknowledgement of its receipt five months later. Since then, the College says that there has been no communication from the Ministry.

- The Royal College of Dental Surgeons of Ontario reported that it submitted a Quality Assurance regulation for approval in 1996 specifying requirements for participation in college Quality Assurance programs and continuing competence. The College reportedly withdrew this request in 1999, and an updated regulation was submitted for approval in September, 2000. In 2003, the College was apparently advised that the Ministry had no record of the regulation, and the College therefore resubmitted the regulation in 2004. Discussions resumed in the summer of 2004, but then apparently stopped. The RCDSO, therefore, is currently without a Quality Assurance regulation. In a letter to HPRAC, the College stated:

  > Members ask, if we say the Quality Assurance Program ... is so important, why is it that government does not share our elevated sense of concern, or place it on as high a priority since the Quality Assurance Regulation has not been passed? The local dental societies have asked us how we can charge for programs, or work with the universities to develop programs that have a fee attached to them when there is no authority for us to require

> them …even though we have issued Guidelines with respect to education in the Quality Assurance program, they clearly do not have the same effect as a Regulation. A Regulation has the cloak of law and legislation, and consequence if there is no compliance.[35]

Many colleges report that regulations have been outstanding for several years. Some examples follow:[36]

- Between 1995 and 2001, The College of Physiotherapy submitted for approval regulations with respect to Advertising, Conflict of Interest, Physiotherapists working for Third Parties, Public Notice of Hearings and Meetings, Record Keeping and Standards of Practice. None of these were apparently approved by the Ministry, and because they were outdated, the College withdrew them in June, 2005.

- The College of Medical Laboratory Technologists states it submitted Registration regulations for approval in 1999. Over a six year period, a lengthy series of proposals were circulated to members and approved by Council as required, and then recirculated and reapproved following Ministry rejection. Finally, in October, 2005, the College was granted its Registration amendment.[37]

- The College of Midwives reports that it submitted a Registration regulation for approval in 1997 to amend a1994 regulation dealing with Prior Learning and Assessment. In 2003, the Prior Learning and Assessment program ended, without there having been a regulation to give it legal status. In 2004, the Ministry requested documentation comparing the 1994 regulation to the 1997 proposals, with rationale for each wording change, purpose and impact. This material was submitted in December, 2004, and there appears to have been no response from the Ministry since that time.[38]

- In 1995, the Royal College of Dental Surgeons of Ontario reports that it submitted for approval a regulation regarding Prescribed Records, specifying requirements for the making and keeping of clinical and financial records. A minor amendment was submitted in 1996. To date, the regulation has not been approved. In the meantime, the College continues to use Regulation 547 as amended to 548/93 under the Health Disciplines Act, which was repealed in 1993.[39]

- The College of Physicians and Surgeons of Ontario reports that it made several regulation requests to the Ministry in 2000 and 2001, none of which have been approved to date.[40] They pertained to the following matters:

---

[35] Letter to Chair of HPRAC, November 28, 2005
[36] Documentation from written submissions to HPRAC
[37] OReg 553/05
[38] Submission to HPRAC, May, 2005
[39] Submission to HPRAC, May, 2005
[40] Letter to Chair of HPRAC, January, 2006

  - Duty to warn
  - Increasing academic representation on Council
  - Methadone program
  - Investigative procedures/Public Hospitals Act inconsistencies
  - Registration

- The College of Nurses of Ontario stated that "delays in regulation approval have had and will continue to have a profound impact on CNO's ability to ensure that the safety of the public is protected, and to facilitate appropriate and timely access to health services its members can provide to the public".[11]

- The College of Occupational Therapists reports that a Professional Misconduct regulation submitted for approval in July, 2001 has undergone five reviews with the Ministry requiring minor changes in each review, and prompting additional review and circulation by the College to members, additional work by legal counsel, and subsequent approval by Council. The approval of this regulation is still pending.[12]

- The College of Psychologists reported to HPRAC that it had submitted amendments to its Registration regulation in 2003 and received queries from the Ministry related, not to the amendments, but to the wording of the regulation that had been in force since 1998.[13]

- The Ministry rejected proposals for a Professional Misconduct regulation relating to Record Keeping submitted by the College of Nurses in 1994 on the grounds that it applied only to nurses working in independent practice. The CNO reports that the regulation was drafted to apply only to nurses in independent practice because they are the only ones who have control over health care records. For other nurses, the facility, employer or hospital has control over health records.[14]

While they appreciate the recent Guidelines for Conflict of Interest and Advertising, colleges continue to seek Ministry guidelines for regulations on: record-keeping (following on new statutes relating to health records), and matters relating to the federal-provincial Mutual Recognition Agreement respecting labour mobility.

The Ministry Perspective

The Ministry's expectation is "that colleges have adhered to [its] the guidelines and have submitted a comprehensive proposal. If the information is not complete, staff must make additional requests for information or clarification that may not be readily available and may take the colleges awhile to respond."[15] Where the quality of the proposal falls short of the standards set out in Ministry guidelines, staff face significant challenges.

---

[11] Submission to HPRAC, November, 2005
[12] COTO report to HPRAC, August, 2005
[13] Submission to HPRAC, November, 2005
[14] Submission to HPRAC, November, 2005
[15] Letter to Chair of HPRAC from Joshua Tepper, ADM, HHRSD, MOHLTC, Dec. 19/05

The Ministry also noted the difficulty of dealing with changes to the proposed regulation after the proposal has begun the approval process. There have been occasions where it was not possible to deal with these changes because they have come forward without having been approved by the council of the college. In other instances, they have not had benefit of legal review, or are not in the form of draft regulations. These factors may contribute to a delay in the approval of regulations.

While colleges report that they are often unaware of the stage of the proposal, or that communication by the Ministry regarding a particular regulation is irregular or absent, the Ministry states in a FAQ to its 2001 Guideline that regulations "may take up to a year before they are filed and gazetted". The Ministry reported to HPRAC that recently it has taken steps to improve the approvals process by designating a single contact person for each submission, and providing timeline expectations to colleges.

8.6 Summary

In its response to HPRAC, the Ministry observed that "some colleges are more sophisticated than others when it comes to regulation proposal development and submission to the ministry". HPRAC notes, however, that the problems cited by the colleges have been raised by colleges with both large and small membership, and with large and small resources to engage internal or external legal counsel.

HPRAC has concluded that a timely, responsive regulation approvals process is a critical component in the delivery of quality accessible health systems. The system that is in place is not working for the colleges, our health professionals, the Minister and Ministry, or the public.

8.7 Regulation Outside of the *RHPA*

Regulation of health professions in Ontario is subject to several pieces of legislation outside of the *Regulated Health Professions Act 1991* and profession-specific Acts. The *Healing Arts Radiation Protection Act*, the *Drugless Practitioners' Act*, the *Drug and Pharmacies Regulation Act*, and the *Drug Interchangeability and Dispensing Fee Act* are just some of many statutes that impact regulated health professionals. Regulations under those Acts bring added complexity to the regulation approval process.

- The Royal College of Dental Surgeons continues to rely on some regulations made under the *Health Disciplines Act*, which was repealed in 1993.

- The College of Nurses submitted regulations under *HARP* in October, 2005 to enable additional diagnostic tests that RN (EC)'s are authorized in order to meet current practice standards.

- The College of Pharmacy must comply with several acts governing the facility as well as the profession, and has recently submitted regulations that are complementary to those under the *RHPA*, and that address current and evolving standards of practice. Some of these must move forward in tandem with *RHPA* regulations if the regulation of pharmacy technicians is to proceed. This is further discussed in Chapter 4 of this report.

An examination of the process for regulation approval when there are several Acts involved, and where the approval of regulations must move forward concurrently would have value.

8.8 HPRAC recommends in regard to the regulation approval process:

55. That a collaborative task force, including representatives from the Federation of Health Regulatory Colleges of Ontario, HPRAC and representatives of the Ministry of Health and Long-Term Care, jointly establish procedures that will

    (a) improve communication and information sharing so that all parties will have the information they need to carry out their responsibilities in the regulation approval process;

    (b) develop a revised template for a general guide to the submission of proposals for regulation that is readily understood and implementable by all colleges;

    (c) develop and execute a communications plan to ensure that both parties fully understand the process, and how to expedite approvals.

56. That the Ministry set accountability standards for its performance in the regulation process, including

    (a) timeliness for acknowledgement and response to regulation proposals;

    (b) ongoing communication with the proponent concerning the status of the proposal;

    (c) adoption of appropriate mechanisms to resolve outstanding issues with Colleges;

    (d) distribution of guidelines and principles respecting regulations;

    (e) processes for regulation approval when there are several Acts involved, and where regulations must be concurrent;

    (f) an internal and external evaluation mechanism to contribute to continuing quality improvement in its regulation activity.

9. Governance

The *Regulated Health Professions Act* recognizes the benefit of lay participation within the self-governance framework of the regulatory colleges. Accordingly, college councils (or boards of directors) are composed of individuals who are members of the profession and individuals representing the public. The goal is to balance the interests of the public and the profession in the disposition of college matters.

Public representatives are appointed by the Lieutenant-Governor-in-Council on the recommendation of the Minister of Health and Long-Term Care. Professional members are elected by their peers according to the by-laws of the college. Depending on the composition of the council specified in each profession's statute, academic members may be included on council. This varies from profession to profession.

Requirements for the composition of colleges' statutory committees and panels are set out in the *HPPC*. Public appointees must be included on all statutory Committees and Panels, and must be included in a quorum for decision-making. Public appointees may serve as committee chairs and may hold executive positions.

In preparation for its 2001 report, HPRAC reviewed the college council structure and advised that no changes be made to the principles of college governance. It suggested that an amendment might be made to the Code to provide that members of a profession have a majority plus one or two over public members. It also recommended that the Minister review with individual colleges the appropriateness of the composition of their councils, and whether the inclusion of academic members should be mandatory. In addition, it made recommendations regarding the selection and training of public members.

9.1 Selection of Public Appointees

The councils of colleges are composed of individuals who are members of the profession and individuals who are public representatives and appointed by the Lieutenant Governor in Council. There is generally an agreed-upon formula that gives professional members a slight balance of power on the council, its committees, and panels of committees that hear complaints, capacity and discipline matters. This is in keeping with the principle of self-regulation. There are also statutory requirements that committees and panels must include public appointees.

HPRAC concurs with previous recommendations that public appointees should be selected on the basis of relevant education and experience. They must have the necessary knowledge, ability, willingness and commitment to fulfill their responsibilities as public members as well as the specific knowledge and skills needed by individual colleges.

HPRAC understands that it is sometimes difficult to choose individuals to serve on councils given the commitment required: for people who are otherwise employed, or who have young families, it is a demanding request that frequently means a loss of income, and considerable investment of time and energy.

9.2 Timely Appointments

As part of the review of the previous report, HPRAC heard that public appointments are often slow to be concluded and that this creates a barrier to effective operations of the Council and its Committees and panels. Without a full complement of public appointees, colleges may not be able to properly constitute Complaints, Discipline and Fitness to Practise Committees as required by the statute.

HPRAC notes that the *RHPA* and the profession-specific acts are silent with respect to specifying the term of office for public members. The practice has been for the Lieutenant-Governor-in-Council to appoint members for a limited term. Recently, HPRAC has observed that some public members have been appointed for a period of only one year. This timeframe is barely adequate to become familiar with the duties and processes of what is fundamentally an adjudicative body, much less to make a valuable contribution to the college.

Some colleges suggested that amendments to the legislation should be made to provide that either a member's term does not expire until his or her successor is appointed and trained, or that councils and committees should be deemed to be properly constituted with the remaining members, whether or not the statutory standards are met. HPRAC notes that Alberta's *Health Disciplines Act* requires that a public appointee "continues to hold office after the expiry of the member's term of office until the member is reappointed or the member's successor is appointed".

Others suggested that non-council members drawn from the public at large be permitted to form part of the quorum of committee panels, thus ensuring their ability to conduct business notwithstanding a vacancy in a public member appointment. Public appointees themselves who participated in a workshop discussion with HPRAC in December, 2005, recommended more timely appointments and that the terms of the appointments be lengthened. This would strengthen the role of public members by providing greater continuity and increasing expertise.

HPRAC does not recommend that statutory change be made at this time to remediate what is essentially an operations issue. We recognize, however, that for many colleges the timely appointment of public members is a critical matter, and concur that the Minister should take whatever steps necessary to support colleges in this regard. There are some options that might be considered to change the pace of the appointments process by eliminating some, but not all, steps in the government appointment approval process.

9.3 HPRAC recommends with respect to public appointments to councils:

57. That public appointees to college councils should be selected on the basis of relevant education and experience: they must have the necessary knowledge, ability, willingness and commitment to fulfill their responsibilities as public members;

58. That the government consider changes to its appointment process to increase the term of public appointments to college councils, or allow an "at pleasure" appointment to continue until the Lieutenant Governor in Council appoints a successor, and

59. That the government consider whether the Minister ought to appoint public members to college councils in lieu of the Lieutenant Governor in Council.

9.4 Information and Training

There was significant support for the 2001 HPRAC recommendation that potential public appointees to college councils receive increased information about their roles and responsibilities. Public appointees told HPRAC that they agree. While all thought the role of public appointees was important, many were unaware of the personal commitment that would be required to fulfill that role. Some suggested that a group of willing volunteers who had previously served on councils might provide information and insight to prospective appointees, and that it would be useful for the Public Appointments Secretariat or colleges themselves to consider such an initiative.

Associations, colleges, the FHRCO, professional members, public appointees and members of the public were unanimous in calling for enhanced training for council members. The concepts of self-regulation are not broadly known. The workings of adjudicative bodies and the responsibilities of adjudicators demand proficiency. Establishing standards and guidelines to guide professional activity is a challenging and vital role that requires knowledge and exactitude. Public appointees, themselves, stressed the importance of knowing the Act and the regulations, and of being prepared to engage in discussions.

Public appointees from all colleges proposed that opportunities be created to facilitate discussion and learning. Those who had participated in basic and advanced training programs on conducting discipline hearings felt they had benefited tremendously. These programs are sponsored by the FHRCO and are available to both professional and public members.

HPRAC has also considered proposals for collaborative self-funded orientation programs, involving members of college councils, the Health Professions Appeal and Review Board, HPRAC and the Ministry would be a useful step. HPRAC proposes to engage in further discussions on this option.

In 2001, HPRAC recommended that it is the responsibility of the colleges to train and orient public members to their role. HPRAC today underlines that training and orientation requirements are not limited to public appointees, but must respond to needs of both public and professional members. Having said that, we note that colleges cover the expenses for training of professional members, and funding for education of public members is allocated by the Ministry. Public members can only avail themselves of this training if the Ministry agrees to cover the cost, or if they pay for programs personally. The reported experience of some public members shows inconsistencies in Ministry funding of council member training.

9.5 Therefore, HPRAC recommends:

60. That there be parity in the provision of funds for the education of all council members, whether appointed or elected, and that Ministry funding for training and orientation of public members be sufficient to enable public appointees to avail themselves of training opportunities on the same basis as professional members of college councils.

9.6 Compensation

Section 8 of the HPPC provides that Council members appointed by the Lieutenant-Governor-in-Council shall be paid expenses and remuneration by the Ministry of Health and Long-Term Care. Public appointees receive an honorarium for their work and some related expenses from the Ministry, with strict guidelines surrounding preparation time required for meetings and hearings. Professional members are compensated by the colleges directly.

Both public appointees and colleges noted the disparity in compensation between public members and professional members. In HPRAC's discussions with people who were public appointees to colleges, it was noted that the compensation level had not changed in twenty years and that this situation needs to be rectified.

The Advisory Council was told that many appointees cannot afford to maintain their role. Others noted that compensation for transportation expenses to attend meeting is inconsistent and arbitrary. HPRAC also heard that public appointees may not be compensated for their preparation time unless it involves a statutory Committee of the council. Because this can involve many hours of work, participants felt that this was unfair and discriminatory. They stated that since there is an expectation that competent people will serve on council Committees, they should be compensated for their time and work.

Significant differences in compensation have also led to the impression that public appointees, who balance the same pressures and demands as professional members, are second-class governors. It is important to restore equilibrium. Public appointees must engage in the governance process fully, and their roles, responsibilities and accountabilities are no less significant than those of the professional members.

HPRAC notes that there should be sufficient compensation to attract a pool of proficient candidates to serve as public members.

9.7 HPRAC recommends:

61. That the government engage in a timely and thorough review of public appointee compensation leading to the enhancement of compensation provided to public appointees to Councils.

10. Controlled Acts and Scopes of Practice

The scope of practice for each profession is described in profession-specific Acts. Controlled acts are the restricted acts that the *RHPA* differently authorizes to each profession in accordance with the competencies demonstrated by those professions. There has not been a thorough review of these provisions since the statute was proclaimed fifteen years ago. This observation alone suggests that it is appropriate to examine whether modifications are warranted in face of new technologies or other influences such as health human resources needs.

Further, it would be useful to examine whether professionals are in fact practicing to the maximum scope of their practice and, if not, what barriers restrict them from doing so. Another aspect of this review would be to shed light on what new roles might be appropriate within a profession and how best practices in cross-professional scopes can be promoted.

62. HPRAC proposes to develop a consultation program that will enable each profession to assess the validity and currency of its scope and authorized acts, and to report to the Minister with its recommendations.

11. Health Human Resources Planning

The regulation of health professionals is a key element in ensuring that appropriate registered professionals are in place to meet identified needs. It takes years of education and clinical practicums to meet the requirements for entry-to-practice in any profession, and continuing competence must be assured so that professionals can adjust to changes in care delivery, disease incidence and population characteristics.

11.1 Data Collection

One of the major elements in health human resources planning is the availability of data that describes the composition of the current professional pool – the base-line. While for nurses and physicians a good deal of aggregated information is available, for most professions, the data is difficult to obtain.

> In general, Canada does not have comprehensive data on HHR. However, high quality data are available for physicians and these data can serve as a model for other health professions. The main data sources are the Southam Medical Database (SMDB) and the Canadian Post-M.D. Education Registry (CAPER). Information on medical students is available on CAPER, while the SMDB contains annually updated information on most physicians in Canada, including a unique scrambled physician's ID, gender, year of birth, province of residence, postal code, activity status, specialty, location and year of graduation from medical school. Analysts can use the SMDB to track career paths over time, specifically, transitions into practice (first entry in the database) and different specialties, periods of illness, temporary absences from active practice, emigration and retirement.[16]

---

[16] Health Canada, Health Policy Research Bulletin, May, 2004

Statistics Canada and the Canadian Institute for Health Information provide some essential data on health care workers, but Ontario planners could make use of information that speaks more specifically to the provincial demographic. This is where the regulatory colleges could play an important role.

In Ontario, the regulatory colleges have dissimilar approaches to collection of data relating to their members. A major contribution to identifying trends in the demographics of health professionals could be made if there were a systematic approach by the colleges to the collection and sharing of information, without personal identifiers, that identifies more completely the composition of each of the professions. Information concerning the aging of professionals that may trigger retirements, the recording of different competencies within a profession, geographic location of practice and gender influences can assist health planners to predict professional supply needs.

While colleges can now collect aggregate information, ensuring that the data is consistent so that it can be measured coherently continues to be an issue. Some minor changes to the *RHPA* could empower colleges to collect information that could be aggregated and utilized effectively in the planning for the education and training of new professionals. It would also assist in predicting where extended classes or revised scopes of practice for some professions might be useful.

11.2 HPRAC recommends:

63. That section 5 of the *RHPA* should be amended by adding the following subsection:

    (a) The Minister may require a Council to provide reports and information for the purposes of administering this Act or for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning.

    Collection of Information from Members

    (b) Each College shall collect from its members, and each member shall provide to the College, the information required to provide the reports to the Minister under subsection (1).

64. That a joint task force should be established to include the Ministry and representatives of the Federation of Health Regulatory Colleges of Ontario to develop consistent criteria for the collection of aggregated data that would be helpful in health human resources and service delivery planning.

11.3 New Classes

HPRAC is concerned that Ontario is lagging behind in the development of new allied professionals to ensure access and reduce wait times for treatment, and that regulatory strictures may hinder regulated professionals in working to the fullest extent of their scopes of practice. Canada, in cooperation with the provinces has developed a 10 year plan directed toward reducing waiting times for access to care, especially for cancer, heart, diagnostic imaging, joint replacement and sight restoration services. In Ontario, the wait-time strategy is targeted to increasing access to care while keeping pace with increasing demands of an aging population.

Anaesthesiology

In Ontario, with a critical shortage of anaesthesiologists, it is useful to look at health human resources experiences in other jurisdictions. In the United States, nurse anaesthetists practice in collaboration with surgeons, obstetricians, dentists, anaesthesiologists and other health professionals in hospitals, ambulatory centres and delivery rooms. Educational qualifications are a two-year didactic and clinical training program in the administration of anaesthesia at the master's level from an accredited nurse anaesthesia program.

> Nurse anesthetists have been providing anesthesia care in the United States for over 125 years. Certified Registered Nurse Anesthetists (CRNAs) are anesthesia professionals who personally administer approximately 65% of all anesthetics given to patients each year in the United States. CRNAs are the sole anesthesia providers in approximately two thirds of all rural hospitals in the United States, enabling these healthcare facilities to offer obstetrical, surgical, and trauma stabilization services. In some states, CRNAs are the sole providers in nearly 100% of the rural hospitals.[17]

Ontario has taken some preliminary steps through a new 22 week training program that will train nurses and respiratory therapists to work as anaesthesia assistants under the supervision of anaesthesiologists.

HPRAC is convinced, however, that a new extended class for nurses in anaesthesiology should be explored, along with competencies and entry-to-practise requirements, educational programs, and issues relating to supervision, delegation, self-initiation and medical orders. Nurse anaesthetists, with their additional skills, could work in collaboration with physicians and other professionals such as dentists, or could support the work of family health teams, hospital surgical programs, and care provided in community health centres. The need has been identified, but regulation of health professionals may not have kept pace.

65. HPRAC proposes to begin consultations that explore regulatory options for extending the role of nurses in the field of anaesthesiology and to make recommendations to the Minister as a priority.

---

[17] American Association of Nurse Anesthetists, February, 2006

Orthopaedics

Ontario has a critical shortage of orthopaedic surgeons as well. The United States has had experience in creating teams that extend the role of specialists in orthopaedics by involving specialist assistant physiotherapists in multidisciplinary teams. They provide general support to orthopaedic surgeons, and conduct their own primary care activities, by evaluating and treating patients with neuromusculoskeletal disorders. These practitioners are clinical specialists with an extended scope of practice.

In the United Kingdom, physiotherapists who have extended scopes work in several major specialties, including musculoskeletal medicine, rheumatology, paediatrics, orthopaedics, neurology and respiratory care. Members of the Chartered Society of Physiotherapists are employed in primary and secondary care settings and interface clinics, and encompass tasks that may previously been undertaken by the medical profession. In Ireland, physiotherapists with extra training have new responsibilities in orthopaedics, back pain screening, fracture and minor injury clinics, along with multi-disciplinary activities in outpatient clinics such as hand injury clinics. They also provide management of elective orthopaedic wait lists, and produce a cost effective and quality service for patients.

Data on wait times across Ontario indicate that for the 52 of 60 hospitals that provide hip replacement services, the average wait time in October/November 2005 was 150 days for patients waiting to complete their surgery or their exam. For the 56 of 60 hospitals that provide knee replacement services, the average wait time was 203 days. Ninety percent of hip replacement services were completed within 341 days and ninety percent of knee replacement services were completed within 431 days.[illegible]

As pressure mounts to meet wait list targets for hip and knee replacements and the population cohort most likely to need these procedures grows, it should be a priority to review whether and how allied professionals can become part of the solution, what new competencies they would require, and how they could be integrated into practice. One again, regulation may not have kept pace with needs in patient care and human resources supply.

66. HPRAC proposes to begin consultations that explore health professions regulatory options for extending the role of physiotherapy orthopaedic specialists and to make recommendations to the Minister as a priority.

Diagnostic and Technological Services

HPRAC is aware of pressures on professional human resources in a number of diagnostic areas, including pathology, medical laboratory technology and medical radiation technology. 70% of medical decisions made and the treatment plans developed are based on medical laboratory test results. The number of diagnostic imaging and medical laboratory procedures is increasing exponentially, and new technologies bring with them a requirement for

---

[illegible] MOHLTC *Wait Times Across Ontario*
http://www.health.gov.on.ca/transformation/wait_times/wt_data/data_ontario.html

new competencies from health professionals, and possibly new classes within professions to meet service demands.

Cancer Care Ontario (CCO) reports

> Several reports on waiting times for diagnostic services describe a growing problem of access to diagnostic imaging. Data compiled on waiting times for CT and MRI reported that 90% of Ontario patients wait longer then medically optimal for the services that are commonly used for cancer diagnosis.[89]

CCO also indicates that cancer incidence (number of new cases) will grow as a result of population growth, aging of the population and increased cancer risk

- In the next 3 years, the number of cancer incidence cases will grow from 54,000 in 2004 to 63,000 in 2007
- 85% of new cancer cases occur in people aged 50 and older
- Cancer survival rates have been improving: the five-year survival rate now exceeds 50% for most cancers.

The capacity to meet this demand is constrained by a number of factors, including health human resources. CCO is developing a province-wide screening program for colorectal cancer, including an assessment of diagnostic activities needed. CCO suggests that

> Part of the human resource solution is to create new non-traditional roles for health care professionals in order to expand capacity.

Demands for diagnostic and technological expertise are being faced in other areas of health care delivery as well.

There are approximately 6,000 Medical Radiation Technologists (MRTs), and 8,000 Medical Laboratory Technologists (MLTs) working in Ontario now, with scopes of practice that were initiated with the introduction of the *RHPA* in 1991.

The College of Medical Radiation Technology of Ontario registers medical radiation technologists in four specialties of medical radiation technology – radiography, nuclear medicine, radiation therapy and magnetic resonance. In addition, it issues two limited employment-specific certificates of registration in nuclear medicine and radiography. The College of Medical Laboratory Technologists of Ontario registers medical laboratory technologists in a number of specialties from clinical chemistry to hematology.

The province's community college programs now graduate approximately 120 new MRTs each year, up from 100 two years ago. In laboratory medicine technologies, approximately 50 LMTs graduate each year, up from 35 two years ago. MRI tecnologists are now trained at the Michener Institute, and approximately 400,000 MRI scans will be performed in Ontario in 2005-2006.

---

[89] Cancer Care Ontario. Ontario Cancer Plan. 2005

67. HPRAC proposes to conduct a review of whether scopes of practice are current in the health professions' diagnostic and technological sectors and whether new classes within these professions are appropriate to meet current and future needs. Advice will be provided to the Minister following this assessment.

12. Appeals and Reviews

HPARB Review

In Section 5 of this report, HPRAC recommends amending the Code to eliminate requests to HPARB for a review in cases where a complaints proceeding was unable to conclude in the timeframe specified by the legislation.

Stays of Orders

In 2001, HPRAC commented on the rights of appeal to Divisional Court, and noted that "an appeal from such a [professional misconduct] finding ought to be viewed primarily from the perspective of the public interest in protection from harm".

> Given the fact that the judicial review process can take many months or years to be concluded, it is not in the public interest to allow for an *automatic* suspension of a discipline panel's order while awaiting the outcome of that review.[50]

In reviewing the previous recommendation and other interventions, HPRAC has concluded that the Act should be more explicit with reference to appeals on decisions relating to incompetence, incapacity and serious sexual abuse to ensure that a member must comply with the order despite an appeal, and the Court should not have the discretion to stay the order.

Clarity

The Health Professions Appeal and Review Board (HPARB) has indicated to HPRAC that the Act as currently written implies in one instance that HPARB conducts appeals of registration decisions, when its mandate is to "hold a review of the application and the documentary evidence in support of it, or a hearing of the application ...", which implies a new examination of the application. HPRAC agrees that there should be consistency in the legislation.

---

[50] *Adjusting the Balance*, page 79

12.1 With respect to Appeals, HPRAC recommends:

68. That section 71 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    No stay of certain orders pending appeal

    71. An order made by a panel of the Discipline Committee on the grounds of incompetence or because of a finding that a member has committed sexual abuse of the kind described in subparagraph i, ii, iii or iv of paragraph 2 of subsection 51 (5), or an order made by a panel of the Fitness to Practise Committee on the grounds of incapacity, directing the Registrar to revoke, suspend or impose terms, limitations or conditions on a member's certificate of registration, takes effect immediately even if an appeal of the order is made, and the Court may not grant a stay of the order until disposition of the appeal.

69. That the title "Appeal to Board" preceding Section 21 (1) of Schedule 2, the Health Professions Procedural Code be amended to read "Hearing or Review of Application by Board".

13. Confidentiality Provisions

The *RHPA* contains a number of provisions relating to access to and sharing of information with the public, including requirements for annual reports, disclosure of information to complainants and members, open council meetings and discipline hearings. It also provides for confidentiality in capacity proceedings and in quality programs.

The Act's confidentiality provisions set tight restrictions on sharing information. College personnel and all members of council or committees must preserve the secrecy of all information unless it is in the public domain or falls within specific exceptions. Some of the provisions in the Act make it impossible for pertinent information to be shared across committees within a college, or limit information that can be provided to a complainant or a person that makes a report. A college is precluded from acknowledging to the public that it is acting on a complaint or conducting an investigation.

With implementation of the changes proposed to the structure of the colleges, HPRAC expects that many of these barriers will be removed and that colleges will be able to share information appropriately. However, some additional changes are needed to allow colleges to disclose information when the purpose of disclosure is to protect the public interest and members of the public from harm.

In its 2001 report, HPRAC recommended additional exemptions to Sec. 36, and noted that:

> Current … provisions do not allow a college to disclose when asked any information to assure the public that the college is acting in its interests. HPRAC contends that it is sometimes preferable for a college to disclose appropriate process information (e.g. that the

> college is investigating a particular matter). This would give colleges the flexibility to communicate currently protected information where it is in the public interest to do so.[31]

In 2006, the Advisory Council holds the same opinion. The current restrictions on releasing information undermine public confidence in the regulation of health professionals, and hinder a college's ability to protect the public when it has reasonable grounds to believe that it has a duty to warn.

HPRAC has reviewed confidentiality provisions of other statutes and the common law, and has found that where the public interest in the release of information outweighs a right to privacy, the conditions for the disclosure of information are often prescribed by regulation. This is a useful mechanism in sharing information with certain non-health regulators or agencies such as the College of Social Workers, Children's Aid Societies, hospitals or the Coroner.

Regarding disclosure to the public of an investigation, however, additional provisions are needed. For example, the Act should specify the circumstances in which information can be disclosed to the public, including, for instance, when the member has made the investigation public or where criminal charges have been laid.

13.1 With respect to the confidentiality provisions of the Act, HPRAC recommends

70. That section 36 of the Regulated Health Professions Act, 1991 be repealed and the following substituted:

> 36. (1) A person employed, retained or appointed for the purpose of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a member of a Council or committee of a College shall not disclose any information that comes to his or her knowledge in the course of his or her duties.
>
> (2) Subsection (1) does not prohibit,
>
> (a) disclosure of information that is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, a regulation under any of those Acts, or the by-laws or rules of practice and procedure made by a College;
>
> (b) disclosure required in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, a regulation under any of those Acts, or the by-laws or rules of practice and procedure

---

[31] *Adjusting the Balance*, page 87

made by a College, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;

(c) disclosure to a body that governs a health profession in Ontario or in a jurisdiction other than Ontario;

(d) disclosure required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Ontario Drug Benefit Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);

(e) disclosure required for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning by the Minister;

(f) disclosure to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(g) disclosure by a person or member to his or her counsel;

(h) disclosure with the written consent of all persons to whom the information relates; or

(i) disclosure to a prescribed entity if the purpose of the disclosure is to protect one or more individuals from harm;

(j) disclosure of an investigation of a member if the disclosure is in the public interest, and in circumstances where:

1. the member has made the investigation a matter of public record, or
2. criminal charges have been laid against the member in connection with the same issue as is being investigated.

14. Shared Service Business Model

The Minister asked HPRAC to review whether there were any impediments in the *RHPA* or the profession specific acts to a shared services business model for new professions for whom the financial demands of regulation are onerous, but where the public interest would be served by regulation.

HPRAC discovered that there were no statutory barriers to the implementation of such a model, but past experience had shown a lack of will to share capital and operating costs and personnel in administrative functions. Colleges who had initiated discussions in the past spoke of difficulties arranging leases to the satisfaction of both parties, and of reaching agreements on human resources policies and practices. Neither are insurmountable obstacles if the parties are willing to proceed. HPRAC also took note of the concerns expressed by smaller professions whose members face increasing costs associated with maintaining both a college and an association, with very distinct roles and responsibilities. In future, some may opt to explore shared business service arrangements.

If two new professions, with separate colleges, were to join in an administrative agreement, there might be advantages in capital and operating planning and other administrative areas. The confidentiality protections and adjudicative functions required of colleges would necessitate some parallel structures and record-keeping, Cost-savings might accrue in shared start-up costs rather than shared restructuring costs. HPRAC is, however, unable to quantify those.

In any event, there is adequate flexibility in the Act for colleges to establish their business arrangements as they see fit, and no additional changes to the Act are required.

HPRAC does observe, however, that as professions seek regulation or changes to existing regulation, it will be useful to consider opportunities for regulation of related professions in one college. This approach can take into account profession-specific needs, while providing the efficiencies that come with having one council and one set of statutory committees. It can also lead to increased teamwork in the development of practice standards and quality programs, and reduce public confusion about similar services provided by members of different professions.

15. Emerging Issues

15.1 Verbal Prescriptions

A particular risk of harm to patients was brought to HPRAC's attention in the course of its review of the regulation of pharmacy technicians, and merit discussion.

Verbal prescriptions or medication orders are prescriptions that are communicated or changed through oral discussion either in person or by telephone. That is, verbal prescriptions are not in writing. Here, the issue concerns public safety and the heightened opportunity for error in completing the prescription or order.

The USP Medication Errors Reporting program concludes that confusion over the similarity of drug names accounts for approximately 25 percent of drug errors. The National Coordinating Council for Medication Error Reporting and Prevention in the United States therefore recommended that[52]

---

[52] NCCMERP, Council Recommendations, February 20, 2001

- Verbal communication of prescription or medication orders should be limited to urgent situations where immediate written or electronic communication is not feasible.
- Health care organizations should establish policies and procedures that:
  - Describe limitations or prohibitions on use of verbal orders
  - Provide a mechanism to ensure validity/authenticity of the prescriber
  - List the elements required for inclusion in a complete verbal order
  - Describe situations in which verbal orders may be used
  - List and define the individuals who may send and receive verbal orders
  - Provide guidelines for clear and effective communication of verbal orders.
- Leaders of health care organizations should promote a culture in which it is acceptable, and strongly encouraged, for staff to question prescribers when there are any questions or disagreements about verbal orders. Questions about verbal orders should be resolved prior to the preparation, or dispensing, or administration of the medication.
- Verbal orders for antineoplastic agents should NOT be permitted under any circumstances. These medications are not administered in emergency or urgent situations, and they have a narrow margin of safety.
- Elements that should be included in a verbal order include:
  - Name of patient
  - Age and weight of patient, when appropriate
  - Drug name
  - Dosage form (e.g., tablets, capsules, inhalants)
  - Exact strength or concentration
  - Dose, frequency, and route
  - Quantity and/or duration
  - Purpose or indication (unless disclosure is considered inappropriate by the prescriber)

  - Specific instructions for use
  - Name of prescriber, and telephone number when appropriate
  - Name of individual transmitting the order, if different from the prescriber.

- The content of verbal orders should be clearly communicated:
  - The name of the drug should be confirmed by any of the following:
    - Spelling
    - Providing both the brand and generic names of the medication
    - Providing the indication for use
- In order to avoid confusion with spoken numbers, a dose such as 50 mg should be dictated as "fifty milligrams...five zero milligrams" to distinguish from "fifteen milligrams...one five milligrams."
  - Instructions for use should be provided without abbreviations. For example, "1tab tid" should be communicated as "Take/give one tablet three times daily."
- The entire verbal order should be repeated back to the prescriber, or the individual transmitting the order, using the principles outlined in these recommendations.
- All verbal orders should be reduced immediately to writing and signed by the individual receiving the order.
- Verbal orders should be documented in the patient's medical record, reviewed, and countersigned by the prescriber as soon as possible.

In HPRAC's review of the regulation of pharmacy technicians, the need for these protocols were underlined by many respondents, who questioned whether regulated pharmacy technicians should be permitted to receive verbal prescriptions:

> Receiving verbal prescriptions is an activity that can and should be questioned. Most health professionals assert that this practice is to be avoided because of the potential for inaccuracy of any verbal prescription.[53]
>
> Humber School of Health Sciences

---

[53] Submission to HPRAC, June, 2005

Cancer Care Ontario recommended to HPRAC that only a pharmacist, and not a pharmacy technician should receive telephone or verbal orders related to antineoplastic drugs, in consideration of safe care regarding these highly toxic preparations. The Canadian Association of Chain Drug Stores references the American Society of Hospital Pharmacists' guidelines[54] in this regard:

> According to the ASHP to prevent errors; only physicians, pharmacists and nurses should be permitted to dictate and receive verbal prescriptions and orders. In many cases, discrepancies are subtle and may not be readily apparent; even to the most experienced practitioners.
>
> Additionally, the potential for error is increased due to the reliance on memory and the variances in individual communication skills/pronunciation. Queries by other health providers regarding therapeutic aspects of an individual's profile often can seem unimportant or trivial during an exchange …Guidelines that have been established to help eliminate errors and enhance patient safety surrounding verbal orders include limiting the number of practitioners permitted to receive verbal orders.

HPRAC notes that patient safety may be jeopardized through verbal prescriptions and medical orders. In an electronic era, it is difficult to understand why the practice continues except in cases of extreme emergency. HPRAC also observes that there is a variation in the approaches of colleges in this regard: the policy statement of the College of Physicians and Surgeons of Ontario on preventing medication errors does not reference verbal medication orders; the Ontario College of Pharmacy includes articles concerning medication safety, but does not speak directly to verbal prescriptions in its online references to prescribing practice; and the College of Nurses of Ontario specifically references communication of verbal prescriptions in its practice standards. In the case of the regulation of pharmacy technicians, HPRAC recommends that receiving verbal prescriptions not be approved for regulated pharmacy technicians, and this is further discussed in chapter 4 of this report to the Minister. Further to that, HPRAC recommends:

71. That protocols surrounding verbal prescriptions should specifically be addressed, individually and jointly, by the Ontario College of Pharmacists and other regulatory colleges whose members are authorized to prescribe medications such as the College of Physicians and Surgeons of Ontario (CPSO); Royal College of Dental Surgeons of Ontario (RCDSO); College of Nurses of Ontario (CNO); and College of Midwives of Ontario (CMO).

15.2 Drug regulations for non-physician prescribers

Matters relating to regulations affecting drug prescribing by non-physician prescribers were also brought to HPRAC's attention.

---

[54] American Society of Hospital Pharmacists. Am J Hosp Pharm. 1993

In January, 2004, the College of Midwives proposed a change to its Drug Regulation when the possibility of a province-wide shortage of a critical drug listed in its regulation was identified. The expedited approval that was requested took nine months.[55] As a result of this experience, the College recommended that the Drug Regulation be changed to list drug classes rather than specific drugs to ensure that midwives are able to practise within currently accepted standards of obstetric care.

The College of Nurses submitted regulations for approval in February, 2002 to amend its Drug Regulation for RN (EC) practice, and received approval in August, 2004. In order to facilitate the eventual approval of the 2002 list, the College removed several medications at the request of the Ministry. One example of a drug removed is Bupropion hydrochloride, better known as Zyban, used for smoking cessation.[56]

The College comments:

> The current drug regulatory approval process for Registered Nurses in the Extended Class (RN (EC)) is a barrier to the delivery of up to date, comprehensive treatment by primary care nurse practitioners in all contexts of practice – long-term care, out-patients' departments of public hospitals (e.g. emergency and ambulatory care), public health units, and family practice. Unless significant revisions are made to the drug prescribing approval process, the problem will worsen dramatically with the regulation of the acute care nurse practitioner role.[57]

Once again, the steps taken by other jurisdictions to remove regulatory hurdles while maintaining appropriate oversight are informative.

In British Columbia, nurse practitioners have been granted broad authority to prescribe, administer or give an order to dispense a drug specified in Schedule I or Schedule II of British Columbia's Drug Schedules Regulation. (Schedule I drugs require a prescription and are dispensed by a pharmacist; Schedule II drugs must be retained in the professional service area of a pharmacy where there is no public access and no opportunity for patient self-selection.)

Nurse practitioners in Saskatchewan have been granted broad authority to prescribe and dispense drugs included in Saskatchewan Health's Formulary and as designated in by-laws of the Saskatchewan Registered Nurses Association.

In early 2005, the United Kingdom Department of Health announced that nurse and pharmacist independent prescribers will be able to prescribe any licensed drug except controlled drugs.

In Ontario, professionals who share the controlled act of prescribing drugs, with the exception of physicians, are now limited to prescribing specific drugs that are named individually in the regulations. This may not enhance collaborative practice, or working in multidisciplinary environments such as Family Health Teams. It may also limit application of emerging innovations in drug therapy, updated clinical guidelines, technological advancements, and use of more economical pharmacological agents.

---

[55] Submission to HPRAC, May 2005
[56] Letter from CNO to Chair, HPRAC, November, 2005
[57] Letter from CNO to Chair, HPRAC, November, 2005

This matter is also discussed in HPRAC's recommendations regarding optometrists prescribing therapeutic pharmaceutical agents in chapter 3 of this report.

72. HPRAC believes that further examination of the individual listing of drugs in regulations for non-physician health professions who are authorized to prescribe is warranted. We propose to undertake that examination and provide advice to the Minister by November, 2006.

15.3 Legislation, Regulation and Guidelines

Legislation provides the legal policy context and framework for Ontario's regulated health professions. It cannot be changed simply or quickly. Regulation is most frequently used where the legislation is silent or treats in a general way a matter that needs to be addressed specifically. At the best of times, the regulation approval process can take significantly more than a year. In situations where practitioners are expected to stay current with fast-paced developments in their fields, colleges increasingly rely on guidelines, policies, rules or standards as mechanisms of governance in place of regulation. While all standards of practice are not recorded, significant policies are published with the expectation they will be incorporated into a member's practice.

Technological change, new diagnostic advances, developments in professional practices, and changing practice conditions are frequently reflected in the college's rules and standards to ensure that members are up-to-date with best practices and are held to account for them. Matters addressed may be as diverse as record-keeping or methadone management. For members, failure to meet the standards of practice of a profession can result in misconduct findings or civil liability.

Regulations are a form of law, and have binding legal effect, and therefore provide an enforcement capability. Guidelines, rules and standards outside of regulations have an uncertain legal effect, however, and may not be enforceable unless they are specifically referenced in the regulation. In his March, 2004 article on "The Legal Effect of Standards and Guidelines", Richard Steinecke addresses the issue of the use of guidelines as opposed to regulations in self-governing professions:[38]

> Most regulators publish informal documents for their members. These documents can be called standards of practice, Guidelines, codes, practice parameters, or position statements. Typically, these informal documents provide assistance to Members in areas of practice, ethics, regulator expectations oreven legal developments.

---

[38] www.sml-law.com/publications/newsletters-detail.asp?DocID=4687

However, unless those documents are enacted in a regulation or similar form of delegated legislation, they are not "legally binding".

In July, 2003 the Ontario Divisional Court upheld findings of the Discipline Committee of the College of Chiropractors relating to assessment, reassessment and record-keeping, and relied on the college's published standards of practice on record-keeping in its decision, and on expert testimony on assessment and reassessment in its decision.[59]

Many colleges have expressed concern that their standards of practice, unless incorporated into regulations or upheld by the court after lengthy and expensive trials, are not enforceable. HPRAC proposes to examine whether more flexible and timely mechanisms other than regulations might ensure that published guidelines and policies (most particularly relating to clinical practice) are enforceable, while still recognizing the public interest. Some early alternatives from other self-regulating professions in Ontario have come to HPRAC's attention.

- The Ontario Securities Commission was given rule-making authority pursuant to the *Securities Amendment Act, 1995*. By delegating this authority to the Commission, the Legislature empowered the Commission to use its expertise to create the detailed rules necessary to meet the purposes of the *Securities Act*. Rules made under the *Securities Act* are binding, and a person or company that contravenes a rule may be subject to enforcement action.

- Lawyers and professional foresters are expressly allowed by statute to make by-laws concerning standards of practice without review or approval of the Minister or Lieutenant Governor in Council. The *Public Accounting Act* authorizes the Ontario Public Accountants Council to develop standards for the profession. Before the standard is finalized, the Council must submit it to the Minister. If the Minister does not provide written objection within 60 days, the standard is deemed to be adopted and has the force of regulations.

- The *Professional Geoscientists Act* allows the governing council of the profession to make regulations on standards of practice; such regulations are subject to the approval of the Minister. Veterinarians, architects and engineers, like health professionals, are authorized to make regulations on practice standards, with such regulations subject to the approval of the Lieutenant Governor in Council.

73. HPRAC proposes a consultative review to examine whether there is a need for change to ensure that college policies and guidelines can be current, reflect best practices and at the same time be legally binding. In the course of that review, HPRAC will identify options as appropriate, and prepare advice for consideration by the Minister.

---

[59] Ressel and College of Chiropractors, Ontario Divisional Court, July 25, 2003

15.4 Regulation of New Professions

The regulation of health professionals under the *RHPA* brings with it an assurance that people who are providing health services meet professional standards and there is recourse if the standards are not met. Most current regulated professionals meet with patients or clients face-to-face, and much of the regulatory surround relates to patient-professional encounters.

Relationship to Patients

Several professions that are currently regulated do not deal directly with patients or clients, but there is potential harm in what they do, and it is expected that members of a college will meet rigourous tests of competence. There is flexibility in the *RHPA* to accommodate those professions.

HPRAC anticipates that there will be other professions that provide integral health services but do not have a direct professional-patient relationship, that will seek regulation under the *RHPA*.

Professionals who provide fundamentally important services in health records management, for instance, spoke to HPRAC about the need to ensure that people who work in this field are properly trained, that they participate in mandated quality improvement programs, and that continuing competency is a necessary part of their professional life. In a field where change is rapid and clinical support must be high, it is appropriate that HPRAC examine the merits of regulation for these health service providers.

Clinical scientists, diagnostic specialists and other professions have proposed regulation under the *RHPA* as the appropriate course to ensure quality and accountability. The *RHPA* is the tool in Ontario for the regulation of health professionals, and for ensuring that the public interest if foremost. HPRAC is convinced that when essential tests are met, the *RHPA* is the appropriate place for regulation of health professionals, whether or not there is a direct and immediate patient or client encounter.

Efficacy

HPRAC found new challenges in its examination of matters posed by the Minister. The question of whether a profession needed to prove the efficacy of its treatments or modalities before the profession could or should be regulated raised issues with respect to the regulation of complementary and alternate medicine practitioners. To HPRAC, the reliance of patients or clients on the therapeutic approach provided by alternate therapists was an important matter. In the practice of homeopathy, for instance, clinical trials are not used, since the profession relies on "provings" that are based on a holistic approach to health care and the "law of similars" as observed in individual patients.

HPRAC has concluded that ultimately, the *RHPA* does not regulate a therapy or a therapeutic approach. It does, however, regulate individuals who practice a form of health care – whether conventional, complementary or alternative – and provides a safeguard for patients or clients who choose to use complementary or alternative medicine practitioners as their first choice of care provider.

16. Moving Forward

When the *RHPA* was first introduced, it was groundbreaking legislation. The recommendations in this report will ensure that the *RHPA* continues to keep Ontario at the leading edge of the regulation of health professionals. Ontario's health care professionals need to be equipped to handle the pace of change in the delivery of health care. The revisions to the *RHPA* suggested here will help Ontario's health professionals respond to new standards, and colleges to effectively and efficiently manage their responsibilities in protecting the public interest. They will help professionals respond to work in collaborative and multi-disciplinary environments. They will also continue to provide choice for Ontarians – in an informed and safe environment.

17. Summary of Recommendations

1. That Section 1 (1) of Schedule 2, Health Professions Procedural Code, should be amended by adding the following definition:

   "public outreach program" means a program to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991* and to enhance relations between and among the College, other Colleges, members, complainants and the public

2. That Section 1 (1) of Schedule 2, Health Professions Procedural Code, should be amended by deleting the definition of "quality assurance program" and substituting the following definition:

   "quality assurance program" means a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members

3. That section (3) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

   Objects of College

   3. (1) The College has the following objects:

      1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.

      2. To develop, establish and maintain:

         (a) standards of qualification for persons to be issued certificates of registration,

(b) programs and standards of practice to assure the quality of the practice of the profession,

(c) standards of knowledge and skill, and programs to promote continuing evaluation, competence and improvement among the members and to address patient concerns and complaints, changes in practice environments, advances in technology, and other emerging issues,

(d) standards of professional ethics for the members,

(e) programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.

3. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

4. To promote interprofessional collaboration with other Colleges as it relates to matters affecting two or more health professions, including, without limiting the generality of this, in connection with anything relating to,

(a) standards of qualification, knowledge and skill for the performance of similar or shared controlled acts,

(b) programs and standards of practice to assure the quality of the performance of the similar or shared controlled acts,

(c) programs to promote continuous evaluation, competence and improvement in the performance of the similar or shared controlled acts, and to address patient concerns and complaints, changes in practice environments, advances in technology and other emerging issues, and

(d) joint investigations of regulated health professionals practicing in multidisciplinary environments.

5. Any other objects relating to human health care that the Council considers desirable.

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest.

4. That section 10. (1) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

10. (1) The College shall have the following committees:
    1. Executive Committee
    2. Registration Committee
    3. Inquiries, Complaints and Reports Committee
    4. Discipline Committee
    5. Fitness to Practise Committee
    6. Quality Committee

5. That section 11. (1) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

    Each committee named in subsection 10 (1) shall regularly monitor and evaluate their processes and outcomes and shall annually submit a report of its activities to the Council in the form that the Council specifies.

6. That section 11. (2) of Schedule 2, Health Professions Procedural Code should be repealed.

7. That section 15 (2) of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

    has doubts, on reasonable grounds based on the applicant's past and present conduct, that the applicant will practice his or her health profession in accordance with the law, or with decency, integrity and honesty.

8. That section 80 of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

    (2) The quality assurance program shall include the following components:

    (a) entry to practise requirements,

    (b) standards of practice,

    (c) continuing education and professional development to promote continuing competence among the members and to address changes in practice environments, clinical standards, advances in technology and other emerging issues,

    (d) self, peer and practice assessments,

    (e) monitoring of members' participation in, and compliance with, the quality assurance program,

    (f) evaluation or monitoring of data respecting complaints and reports, assessment and remediation processes and competence requirements to promote systemic improvement,

    (g) interprofessional collaboration concerning the provision of quality care, continuous improvement in care and patient safety, or any matter described in clauses (a) to (g) as it affects the performance of similar or shared controlled acts.

9. That Sections 83 (3) of Schedule 2, Health Professions Procedural Code, should be repealed and the following substituted:

Referrals to Inquiries, Complaints and Reports Committee

(3) If the Quality Committee is of the opinion, based on an assessment, that a member may have committed an act of professional misconduct or may be incompetent or incapacitated, the Committee may disclose the name of the member and allegations against the member to the Inquiries, Complaints and Reports Committee.

10. That Sections 83.1 of Schedule 2, Health Professions Procedural Code, should be amended by adding the following subsection:

Orders by Quality Committee

(9) The Quality Committee may do any one or more of the following:

1. Require the member to participate in a specified continuing education or remediation program or a self, peer or practice assessment.

2. Monitor the member's progress in the specified program or assessment and reconsider the member's practice upon its completion.

3. Refer the member to the Inquiry, Complaints and Reports Committee for a failure to co-operate with the Quality Committee or any assessor it appoints or to participate in the quality assurance program or a specified program or assessment.

11. That Sections 84 and 85 of Schedule 2, Health Professions Procedural Code, should be repealed and the following substituted:

84. (1) The College shall have a public outreach program.

(2) The public outreach program shall include the following components:

(a) programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*,

(b) measures to enhance relations between and among the College, other Colleges, members, complainants and the public, including without limitation,

vii. notices to complainants and members,

viii. employer and facility relations,

ix. media relations,

x. public register, public hearings and Internet publications,

xi. reports to the Minister and the Health Professions Regulatory Advisory Council,

xii. interprofessional collaboration with other Colleges,

(c) measures for preventing or dealing with sexual abuse of patients.

(3) The measures for preventing or dealing with sexual abuse of patients must include,

(a) educational requirements for members;

(b) guidelines for the conduct of members with their patients;

(c) training for the College's staff; and

(d) the provision of information to the public.

(4) The Council shall give the Health Professions Regulatory Advisory Council a written report describing the public outreach program and, when changes are made to the program, a written report describing the changes.

85. Each Committee of the College shall advise the Council with respect to the public outreach program.

12. That Section 85.7 (3) of Schedule 2, Health Professions Procedural Code, should be repealed.

13. That wherever the words "Complaints Committee" appear in the *RHPA* or in the Health Professions Procedural Code, they should be replaced by the words "Inquiries, Complaints and Reports Committee", and that wherever the words "Quality Assurance Committee" appear in the *RHPA* or in the Health Professions Procedural Code they should be replaced by the words "Quality Committee".

14. That section 6 of the *RHPA* should be repealed, and the following substituted:

(1) Each College shall provide to the Minister, within the time and in the form that the Minister specifies, the plans, reports, financial statements, including audited financial statements, and information that the Minister requires for the purposes of administering this Act or for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning.

(2) The Advisory Council shall report annually to the Minister on its activities and financial affairs.

(3) Each College shall collect from its members, and each member shall provide to the College, the information required to provide the reports to the Minister under subsection (1) and the reports to the Advisory Council under section 11.

(4) Each College shall publish on its website on the Internet general information including, but not limited to:

(g) its role, responsibilities, programs and processes;

(h) the scopes of practice of the health professions it governs;

(i) the use of titles by its members;

(j) what constitutes professional misconduct for its members;

(k) how to access the public portion of the register;

(l) any other general information that the Minister specifies.

(5) Each College shall publish on its website on the Internet, within the time and in the form that the Minister specifies, its audited financial statements and general and statistical information on its,

(a) registration reviews and hearings;

(b) complaints reviews and hearings;

(c) discipline hearings;

(d) fitness to practise assessments;

(e) quality assurance assessments;

(f) other programs and processes that the Minister specifies.

15. That Section 23 (3) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

(3) A person may obtain, during normal business hours and on the College's website, the following information contained in the register:

1. Information described in clauses (2) (a), (b), (c), (d.1) and (d.2).

2. Information described in clause (2) (d) relating to a suspension that is in effect.

2.1 Information described in clause (2) (d.3) relating to a revocation or suspension that is in effect.

3. The results of every disciplinary and incapacity proceeding,

    i. in which a member's certificate of registration was revoked or suspended or had terms, conditions or limitations imposed on it, or

    ii. in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the register by a panel of the Discipline or Fitness to Practise Committee.

3.1 For every disciplinary proceeding, completed at any time before the time the register was prepared or last updated, in which a member was found to have committed sexual abuse, as defined in clause 1 (3) (a) or (b), the results of the proceeding.

3.2 Information described in clause (2) (e.1) related to appeals of findings of the Discipline Committee.

4. Information designated as public in the by-laws.

16. That Section 23 (6) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

(6) The Registrar shall provide to a person, upon the payment of a reasonable charge, a paper or electronic copy of any information in the register a person may obtain.

17. That Section 56 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Publication of Decisions

(1) The College shall publish a panel's decision and its reasons, or a summary of its reasons, on its website as soon as the decision is released and in its annual report and may publish the decision and reasons or summary in any other publication of the College.

18. That Section 23 (2) of Schedule 2, the Health Professions Procedural Code should be amended by adding a new subsection as follows:

a notation of every complaint and report filed with the College and the disposition of the complaint and report.

19. That section 25 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Investigation of complaints and reports

25. (1a) A complaint or report filed with the Inquiry, Complaints and Reports Committee regarding the conduct or actions of a

member shall be investigated by College personnel at the direction of a panel selected by the chair of the Committee.

(1b) The panel shall monitor the progress of the investigation, request additional information from the investigator when necessary, and consider the results of the investigation.

(1c) Where a complaint or report concerns a service provided in a multidisciplinary environment, the investigator may conduct or participate in an investigation of the complaint or report together with one or more investigators from or appointed by other Colleges, and may share information with the other investigators for the purposes of the investigation.

20. That section 25 (2) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

(2) A panel shall be composed of at least three members of the Inquiries, Complaints and Reports Committee, at least one of whom shall be a person appointed by the Lieutenant Governor in Council.

21. That section 25 (4) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

(4) A complaint must be in writing or recorded on a tape, film disk or other medium before it can be considered by a panel.

22. That section 25 (5) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Notice to member

(5) The panel shall give the member who is the subject of a complaint or report immediate notice of the complaint or report and of the provisions of subsection 26 (1).

Notice to complainant or reporter

(6) The panel shall give the complainant or reporter who filed the complaint or report written notice of receipt of the complaint or report, a general explanation of the College's processes concerning the complaint or report and an expected date of disposition of the complaint or report.

23. That section 26 (2) of Schedule 2, the Health Professions Procedural Code be repealed and the following substituted:

Powers of panel

(2) A panel, after considering the results of an investigation of a complaint or report and the submissions of the member and after considering or making reasonable efforts to consider all records

and documents it considers relevant to the complaint or report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or report.

2. Refer the member to the Fitness to Practise Committee for incapacity proceedings.

3. Require the member to appear before the panel to be cautioned.

4. Require the member to complete a specified continuing education or remediation program.

5. Require the member to undergo a physical, psychological, practice or other assessment.

6. Accept a voluntary undertaking of the member.

7. Facilitate and monitor the progress of any alternative resolution processes between the complainant and the member before referring an allegation to the Discipline Committee or a member to the Fitness to Practise Committee.

8. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws.

24. That section 26 (3) of Schedule 2, the Health Professions Procedural Code should be repealed.

25. That section 27 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Notice of decision

27. A panel shall give the complainant and the member who is the subject of the complaint,

(a) a copy of its decision;

(b) a copy of its reasons, if the panel decided to take no action with respect to a complaint or to do anything under paragraph 3, 4, 5, 6 or 8 of subsection 26 (2); and

(c) a notice advising the member and the complainant of any right to request a review they may have under subsection 29 (2).

26. That section 28 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

28. (1) A panel shall use its best efforts to dispose of a complaint within 150 days after the filing of the complaint in writing.

(2) If a panel has not disposed of a complaint within 150 days after the filing of the complaint, the panel shall provide the complainant and the member with written notice of and reasons for the delay in disposition, and an expected date of disposition.

(3) If a panel has not disposed of a complaint by the expected date of disposition described in subsection 28 (2), the panel shall provide the complainant and the member with written notice of the progress of the investigation of the complaint and the new expected date of disposition every thirty days until the complaint is disposed of.

27. That section 26 (1) (a) of the *RHPA* should be repealed.

28. That section 36 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

DISCIPLINE

Inquiries, Complaints and Reports Committee Referral

36. (1) The Inquiries, Complaints and Reports Committee may refer a specified allegation of a member's professional misconduct or incompetence to the Discipline Committee.

Allegations of sexual abuse

(2) In deciding whether or not to refer an allegation of the sexual abuse of a patient to the Discipline Committee, the Inquiries, Complaints and Reports Committee shall take into account any opinion, required under subsection 85.3 (5), as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future.

Idem

(3) The Inquiries, Complaints and Reports Committee shall refer a substantiated obligation of the sexual abuse of a patient of the kind described in subparagraph i, ii, iii or iv of paragraph 2 of subsection 51(5) to the Discipline Committee.

29. That section 37 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Interim suspension

37. (1) The Inquiries, Complaints and Reports Committee may, subject to subsection (5), make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if,

(a) an allegation is referred to the Discipline Committee; and

(b) it is of the opinion that the conduct of the member exposes or is likely to expose his or her patients to harm or injury.

30. That section 37 (5) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Restrictions on orders

(5) No order shall be made under subsection (1) with respect to a member unless the member has been given,

(a) notice of the Inquiries, Complaints and Reports Committee's intention to make the order; and

(b) at least fourteen days to make written submissions to the Inquiries, Complaints and Reports Committee.

31. That section 57, Schedule 2, the Health Professions Procedural Code should be repealed.

32. That section 58 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Appointment of health assessor

58. (1) The Registrar may appoint one or more health assessors to determine whether a member is incapacitated if the Inquiries, Complaints and Reports Committee has received a written complaint or report about the member and has requested the Registrar to conduct a health assessment.

Notice to member

(2) The Inquiries, Complaints and Reports Committee shall give a member notice that it intends to request the appointment of a health assessor to inquire into whether the member is incapacitated before the Registrar makes the appointment.

33. That section 59 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Inquiries by health assessor

59. (1) A health assessor shall make inquiries the health assessor considers appropriate.

Physical or mental examinations

(2) If, after making inquiries, a health assessor has reasonable and probable grounds to believe that the member who is the subject of the assessment is incapacitated, the Inquiries, Complaints

and Reports Committee may require the member to submit to physical or mental examinations conducted or ordered by a health professional specified by the health assessor and may, subject to section 63, make an order directing the Registrar to suspend the member's certificate of registration until he or she submits to the examinations.

34. That section 60 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Health assessor's report

60. A health assessor shall report to the Inquiries, Complaints and Reports Committee and shall give a copy of the report and a copy of any report on an examination required under subsection 59 (2) to the member who was the subject of the assessment.

35. That section 61 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Referral to Fitness to Practise Committee

61. After receiving the report of a health assessor, the Inquiries, Complaints and Reports Committee may refer the matter to the Fitness to Practise Committee.

36. That section 62 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Interim suspension

62. (1) The Inquiries, Complaints and Reports Committee may, subject to section 63, make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if,

(a) it has referred a matter involving the member to the Fitness to Practise Committee; and

(b) it is of the opinion that the physical or mental state of the member exposes or is likely to expose his or her patients to harm or injury.

Procedure following interim suspension

(2) If an order is made under subsection (1) by the Inquiries, Complaints and Reports Committee in relation to a matter referred to the Fitness to Practise Committee,

(a) the College shall prosecute the matter expeditiously; and

(b) the Fitness to Practise Committee shall give precedence to the matter.

Duration of order

(3) An order under subsection (1) continues in force until the matter is disposed of by a panel of the Fitness to Practise Committee.

37. That section 63 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Restrictions on orders

63. No order shall be made with respect to a member by the Inquiries, Complaints and Reports Committee under subsection 59 (2) or 62 (1) unless the member has been given,

(a) notice of the intention of the Committee to make the order;

(b) at least fourteen days to make written submissions to the Committee; and

(c) in the case of an order by the Committee under subsection 62 (1), a copy of the provisions of section 62.

38. That section 75 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Investigators

75. The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,

(a) the Inquiries, Complaints and Reports Committee has received a report from the Quality Committee with respect to the member and has requested the Registrar to conduct an investigation; or

(b) the Inquiries, Complaints and Reports Committee has received a written complaint or report about the member and has requested the Registrar to conduct an investigation.

39. That section 79 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Report of investigation

79. The Registrar shall report the results of an investigation to the Inquiries, Complaints and Reports Committee.

40. That a new definition of be alternate resolution be added to the Health Professions Procedural Code as follows:

"alternate resolution process" includes mediation, conciliation, negotiation or any other means of facilitating the resolution of issues in dispute.

41. That a new section be added to the Health Professions Procedural Code as follows:

Alternate Resolution

1. A panel of the Inquiries, Complaints and Reports Committee may direct a complainant and the member who is the subject of the complaint to participate in an alternate resolution process for the purposes of resolving the complaint or an issue arising from the complaint, unless the complaint relates to an allegation that the member has committed sexual abuse of the kind described in subparagraph i, ii, iii, iv or v of paragraph 2 of subsection 51 (5).

2. All settlements achieved by means of an alternate resolution process must be reviewed and approved by the panel.

3. If the panel approves of a settlement, it shall create a written record of the process conducted containing, at a minimum, a description of the settlement reached and the matters disclosed during the process, and shall place this record on the register maintained by the Registrar.

4. If a settlement cannot be reached using the alternate resolution process or if the Inquiries, Complaints and Reports Committee refuses to approve the settlement, the usual process of the Inquiries, Complaints and Reports Committee shall commence.

5. An alternate resolution process may only be used if,

   (a) the complainant and the member consent, on an informed and voluntary basis, to participate in the process,

   (b) the Inquiries, Complaints and Reports Committee has made written rules concerning use of the process [including rules on full and frank disclosure of all matters and comprehension by both the complainant and the member of the language used].

   (c) the rules provide that a person appointed to help resolve a matter by means of this process may be a member of the Inquiries, Complaints and Reports Committee or a person independent of the Committee; however, a member of the Committee who is so appointed shall not subse quently deal with the matter if it comes before the Committee unless the complainant and the member consent.

6. No person appointed to help resolve a matter by means of an alternate resolution process shall be compelled to give testimony or produce documents in a proceeding with respect to matters that come to his or her knowledge in the course of his or her assistance other than a proceeding under the *Regulated Health Professions Act*, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*.

7. No record, document or thing prepared for or statement given concerning an alternate resolution process is admissible in a proceeding other than a proceeding under the *Regulated Health Professions Act*, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*.

42. That section 85.1 of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

    A member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same of different College has sexually abused a patient or has committed an act of professional misconduct or may be incompetent or incapacitated.

43. That section 85.2 of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

    A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds, obtained in the course of practising the profession, to believe that a member who practises at the facility has sexually abused a patient or has committed an act of professional misconduct or may be incompetent or incapacitated.

44. That section 85.3 (1) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

    A report required under section 85.1, 85.2 or 85.5 must be filed in writing with the Inquiries, Complaints and Reports Committee of the College of the member who is the subject of the report.

45. That Section 85.3 (2) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

    Timing of report

    (2) A report required under section 85.1, 85.2 or 85.5 must be filed within thirty days after the obligation to report arises unless, in the case of a report of sexual abuse, the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse

other patients or, in other cases, the person who is required to file the report has reasonable grounds to believe that the member is putting his or her patients at immediate risk of harm, in which case the report must be filed forthwith.

46. That Section 85.3 (3) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Contents of report

(3) The report must contain,

(a) the name of the person filing the report;

(b) the name of the member who is the subject of the report;

(c) an explanation of the alleged sexual abuse, act of professional misconduct, incompetence, incapacity or revocation, suspension or imposition of restrictions on privileges or employment.

(d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4).

47. That Section 85.5 of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Reporting by employers, etc.

85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges or employment of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Inquiries, Complaints and Reports Committee within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons.

Same

(2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Inquiries, Complaints and Reports Committee within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act.

Application

(3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in

partnership or otherwise with a member for the purpose of offering health services.

48. That Section 85.6 of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

Co-operation with Inquiries, Complaints and Reports Committee

> 85.6 (b) Every person who files a report under section 85.1, 85.2, 85.4 or 85.5, and every person who may have relevant information about the member who is the subject of the report shall co-operate with the Inquiries, Complaints and Reports Committee and with any investigator it appoints and in particular shall,
>
> (a) permit the investigator to enter and inspect the premises where the member practices;
>
> (b) permit the investigator to inspect the member's records of the care of patients;
>
> (c) give the Committee or the investigator the information in respect of the care of patients or in respect of the member's records of the care of patients the Committee or investigator requests in the form the Committee or investigator specifies; and
>
> (d) confer with the Committee or the investigator if requested to do so by the Committee.

49. That section 1 of the *RHPA* should be amended by adding the following definition:

> "bodily harm" means any harm, hurt or injury, whether physical, psychological or emotional, that interferes in a substantial way with the integrity, health or well-being of an individual;

50. That section 30 (1) of the *RHPA* should be repealed and the following substituted:

> No person, other than a member treating or advising within the scope of practice of his or her health profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably forseeable that serious bodily harm may result from the treatment or advice or from an omission from them.

51. That Sections 33 and 43(1)(d) of the *RHPA* should be repealed, and the following substituted:

> 34. (1) No person shall use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals.

(2) Subsection (1) does not apply to a person who,

(a) is a member of a College; and

(b) holds an earned doctorate degree in the discipline in which the person is registered by the College.

(3) In this section,

"abbreviation" includes an abbreviation of a variation; and

"earned doctorate degree" means a doctorate degree granted by an educational institution that is accredited or approved by a certifying body that is approved by the College.

(4) No person shall, orally or in writing, use the title "doctor", a variation or abbreviation or an equivalent in another language, under subsection (2) without indicating the discipline in which the person holds the doctorate.

52. That section 11 (1) of the *Nursing Act, 1991* should be repealed and the following substituted:

    No person other than a member shall use the title "nurse", "registered nurse", "nurse practitioner" or "registered practical nurse", a variation or abbreviation or an equivalent in another language.

53. That section 11 (5) of the Nursing Act, 1991 should be repealed and the following substituted:

    No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a nurse, registered nurse, nurse practitioner or practical nurse or in a specialty of nursing.

54. It is the intention of HPRAC to conduct a further review and consultations on the use of titles in the profession of psychology, with a view to presenting recommendations to the Minister by October, 2006.

55. That a collaborative task force, including representatives from the Federation of Health Regulatory Colleges of Ontario, HPRAC and representatives of the Ministry of Health and Long-Term Care, jointly establish procedures that will

    (a) improve communication and information sharing so that all parties will have the information they need to carry out their responsibilities in the regulation approval process;

    (b) develop a revised template for a general guide to the submission of proposals for regulation that is readily understood and implementable by all colleges;

    (c) develop and execute a communications plan to ensure that both parties fully understand the process, and how to expedite approvals.

56. That the Ministry set accountability standards for its performance in the regulation process, including

    (a) timeliness for acknowledgement and response to regulation proposals;

    (b) ongoing communication with the proponent concerning the status of the proposal;

    (c) adoption of appropriate mechanisms to resolve outstanding issues with Colleges;

    (d) distribution of guidelines and principles respecting regulations;

    (e) processes for regulation approval when there are several Acts involved, and where regulations must be concurrent;

    (f) an internal and external evaluation mechanism to contribute to continuing quality improvement in its regulation activity.

57. That public appointees to college councils should be selected on the basis of relevant education and experience: they must have the necessary knowledge, ability, willingness and commitment to fulfill their responsibilities as public members.

58. That the government consider changes to its appointment process to increase the term of public appointments to college councils, or allow an "at pleasure" appointment to continue until the Lieutenant Governor in Council appoints a successor.

59. That the government consider whether the Minister ought to appoint public members to college councils in lieu of the Lieutenant Governor in Council.

60. That there be parity in the provision of funds for the education of all council members, whether appointed or elected, and that Ministry funding for training and orientation of public members be sufficient to enable public appointees to avail themselves of training opportunities on the same basis as professional members of college councils.

61. That the government engage in a timely and thorough review of public appointee compensation leading to the enhancement of compensation provided to public appointees to Councils.

62. HPRAC proposes to develop a consultation program that will enable each profession to assess the validity and currency of its scope and authorized acts, and to report to the Minister with its recommendations.

63. That section 5 of the *RHPA* should be amended by adding the following subsection:

(a) The Minister may require a Council to provide reports and information for the purposes of administering this Act or for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning.

Collection of Information from Members

(b) Each College shall collect from its members, and each member shall provide to the College, the information required to provide the reports to the Minister under subsection (1).

64. That a joint task force should be established to include the Ministry and representatives of the Federation of Health Regulatory Colleges of Ontario to develop consistent criteria for the collection of aggregated data that would be helpful in health human resources and service delivery planning.

65. HPRAC proposes to begin consultations that explore regulatory options for extending the role of nurses in the field of anaesthesiology and to make recommendations to the Minister as a priority.

66. HPRAC proposes to begin consultations that explore health professions regulatory options for extending the role of physiotherapy orthopaedic specialists and to make recommendations to the Minister as a priority.

67. HPRAC proposes to conduct a review of whether scopes of practice are current in the health professions' diagnostic and technological sectors and whether new classes within these professions are appropriate to meet current and future needs. Advice will be provided to the Minister following this assessment.

68. That section 71 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

No stay of certain orders pending appeal

71. An order made by a panel of the Discipline Committee on the grounds of incompetence or because of a finding that a member has committed sexual abuse of the kind described in subparagraph i, ii, iii or iv of paragraph 2 of subsection 51 (5), or an order made by a panel of the Fitness to Practise Committee on the grounds of incapacity, directing the Registrar to revoke, suspend or impose terms, limitations or conditions on a member's certificate of registration, takes effect immediately even if an appeal of the order is made, and the Court may not grant a stay of the order until disposition of the appeal.

69. That the title "Appeal to Board" preceding Section 21 (1) of Schedule 2, the Health Professions Procedural Code be amended to read "Hearing or Review of Application by Board".

70. That section 36 of the *Regulated Health Professions Act, 1991* be repealed and the following substituted:

> 36. (1) A person employed, retained or appointed for the purpose of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a member of a Council or committee of a College shall not disclose any information that comes to his or her knowledge in the course of his or her duties.
>
> (2) Subsection (1) does not prohibit,
>
> (a) disclosure of information that is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, a regulation under any of those Acts, or the by-laws or rules of practice and procedure made by a College;
>
> (b) disclosure required in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, a regulation under any of those Acts, or the by-laws or rules of practice and procedure made by a College, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;
>
> (c) disclosure to a body that governs a health profession in Ontario or in a jurisdiction other than Ontario;
>
> (d) disclosure required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Independent Health Facilities Act*, the *Laboratory and Specimen Collection Centre Licensing Act*, the *Ontario Drug Benefit Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);
>
> (e) disclosure required for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning by the Minister;
>
> (f) disclosure to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;
>
> (g) disclosure by a person or member to his or her counsel;

(h) disclosure with the written consent of all persons to whom the information relates; or

(i) disclosure to a prescribed entity if the purpose of the disclosure is to protect one or more individuals from harm;

(j) disclosure of an investigation of a member if the disclosure is in the public interest, and in circumstances where:
  1. the member has made the investigation a matter of public record, or
  2. criminal charges have been laid against the member in connection with the same issue as is being investigated.

71. That protocols surrounding verbal prescriptions should specifically be addressed, individually and jointly, by the Ontario College of Pharmacists and other regulatory colleges whose members are authorized to prescribe medications such as the College of Physicians and Surgeons of Ontario (CPSO); Royal College of Dental Surgeons of Ontario (RCDSO); College of Nurses of Ontario (CNO); and College of Midwives of Ontario (CMO).

72. HPRAC believes that further examination of the individual listing of drugs in regulations for non-physician health professions who are authorized to prescribe is warranted. We propose to undertake that examination and provide advice to the Minister by November, 2006.

73. HPRAC proposes to examine through a consultative program whether there is a need for change to ensure that college policies and guidelines can be current, reflect best practices and at the same time be legally binding. In the course of that review, HPRAC will identify options as appropriate, and prepare advice for consideration by the Minister.

REGULATION OF OPTOMETRISTS

The Minister's Question

On February 7, 2005, the Minister of Health and Long-Term Care asked the Health Professions Regulatory Advisory Council (HPRAC) for advice on:

> The currency of, and any additions to, the [Advisory] Council's recommendations in relation to optometrists prescribing therapeutic pharmaceutical agents.[1]

The current scope of practice for optometry does not include prescribing therapeutic pharmaceutical agents (TPAs).

HPRAC's Response

HPRAC's central recommendation is that Ontario optometrists be permitted to prescribe therapeutic pharmaceutical agents with the exception of anti-glaucoma agents. The Advisory Council reached this conclusion following an extensive review of the evidence, including the patient safety record in jurisdictions where the practice is allowed, the curricula of Canadian university programs in optometry, and the qualifications of graduates from those programs.

1. History of the Referral

The current optometry referral has a relatively long history. Originally requested by the Minister of Health in March 1994, investigation of the issue was deferred until 1998 when the Minister asked for HPRAC's advice on expanding the scope of practice for optometry to allow for the use of TPAs. In its report (2000), HPRAC concluded that the evidence did not support expanding the authorized acts in the practice of optometry to include prescribing TPAs.[2] The Ontario Association of Optometrists (OAO) was dissatisfied with this outcome and, three years later, submitted a request to permit the prescribing of TPAs by optometrists. Its request was followed by a month-long period of stakeholder consultations jointly conducted by the OAO and the Ministry of Health and Long-Term Care. Feedback was presented in April, 2003 in the OAO's report "Stakeholder Consultations considering the OAO Proposal to Extend the Scope of Practice of Optometry in Ontario." Based on these findings, the Minister requested HPRAC to provide further advice.

In considering the matter, HPRAC identified three options:

1. Do not grant optometrists the authority to prescribe TPAs (the status quo);

---

[1] Minister's Referral Letter, February 2005, Appendix A

[2] Health Professions Regulatory Advisory Council. "Advice to the Minister of Health and Long-Term Care: Optometry – Use of Therapeutic Pharmaceutical Agents (TPAs)" April 2000.

2. Grant optometrists the authority to prescribe the full list of TPAs identified in the OAO submission;

3. Restrict optometrists' authority to prescribe:
    a) TPAs for certain eye diseases or disorders;
    b) On the basis of delivery method (topical or oral).

Implementation of options 2. or 3. would require a change to *The Optometry Act, 1991* to add the new authorized act of prescribing drugs as set out in regulation.

2. The Consultation Process

To obtain advice on relevant issues, HPRAC invited and received written submissions from the public, associations and professional organizations. Sixteen submissions were filed by practitioners, members of the public, professional associations and professional colleges. These were reviewed, along with the Association's detailed response to an extensive questionnaire from HPRAC concerning the need and rationale for the proposed expansion to the acts qualified optometrists are authorized to perform.[3]

Eleven follow-up consultations were held with the colleges and associations of affected or interested professions. HPRAC also invited members of consumer health associations that provide support to people whose diseases or conditions affect eye health to attend one of four focus group sessions. These sessions were also open to the public. Telephone interviews were conducted with people who wished to comment but were unable to attend a focus group.

To supplement the consultative process, HPRAC conducted literature and jurisdictional reviews as well as consultations with stakeholders and professional authorities. HPRAC also engaged an independent pharmacological expert who examined the requested list of authorized pharmaceutical categories and sub-categories. Finally, the Advisory Council took into account stakeholder consultations conducted in 2003 by the Ontario Association of Optometrists and the Ministry of Health and Long-Term Care.[4]

3. Background

Opticians, optometrists, ophthalmologists and family physicians provide eye-care services in Ontario. Each profession has a defined scope of practice related to those services, which describes the range and type of services provided. Within the current system, patients must visit their family physicians or medical specialists such as an ophthalmologist to obtain prescriptions for eye medications.

---

[3] Submissions are posted on the HPRAC website, www.hprac.org

[4] Stakeholder Consultations Considering the OAO Proposal to Extend the Scope of Practice of Optometry in Ontario, Ontario Association of Optometrists, April 30, 2003.

3.1 What is an Optometrist?

The *Optometry Act, 1991*, describes the practice of optometry as "the assessment of the eye and vision system leading to the diagnosis, treatment and prevention of:

(a) disorders of refraction;
(b) sensory and oculomotor disorders and dysfunctions of the eye and vision system; and
(c) prescribed diseases."

Optometrists play a leading role in the vision care of nearly three million Ontarians annually.[5] Of the thirteen controlled acts defined in the *Regulated Health Professions Act (RHPA), 1991*, the *Optometry Act* authorizes optometrists to:

1. communicate a diagnosis identifying, as the cause of a person's symptoms, a disorder of refraction, a sensory or oculomotor disorder of the eye or vision system or a prescribed disease;
2. apply a prescribed form of energy; and,
3. prescribe or dispense, for vision or eye problems, subnormal vision devices, contact lenses or eye glasses.

3.2 Education and Training

There are two schools of optometry in Canada – the University of Waterloo and the University of Montreal. Both, along with seventeen schools in the United States, are accredited by the Accreditation Council on Optometric Education. The curriculum at these schools encompasses both academic and clinical training components.

On average, students examine 1,500 patients during their training. Many patients are seen at therapeutic training sites. Since 1995, all University of Waterloo students have been placed in a four-month supervised clinical therapeutics externship, predominately outside of Ontario, where they have obtained experience in the therapeutic management of ocular disease. Externships are four months in duration.

Graduates come away with the skills to therapeutically manage eye conditions, including ocular surface diseases, eye and eyelid infections, ocular inflammation and pain, ocular allergies, and glaucoma. Graduates of either Canadian school are able to practice optometry in all Canadian and U.S. jurisdictions, including those where optometrists are permitted to prescribe TPAs.

Waterloo's School of Optometry incorporates two courses related to the preparation for prescribing TPAs. They are Introductory Clinical Pharmacology, and Clinical Ocular Pharmacology.

---

[5] Submission to the Health Professions Regulatory Advisory Council by the Ontario Association of Optometrists, April 2005, pg 5.

Introductory Clinical Pharmacology includes the study of general pharmacokinetic and pharmacodynamic principles, as well as the application of these theories on various systems of the body. Details of drug administration, absorption, distribution, metabolism and elimination are studied, as are receptor classification, quantitative relationships describing dose-response, and factors governing individual response variability. Application reviews focus on systemic medications used to treat most major diseases, such as cardiovascular, neuromuscular, central nervous system and endocrine disturbances, as well as infection, inflammation and pain. Instructors emphasize mechanisms of action, contraindications, factors governing response variability, adverse ocular and systemic drug reactions, and how adverse reactions can be prevented or recognized and monitored.

Clinical Ocular Pharmacology emphasizes the pharmacological and therapeutic principles of drug absorption following topical application, including the distribution, metabolism, mechanisms of action, and elimination from ocular tissues. Students examine, in detail, adverse effects for ocular and other tissues, considering the possibility of systemic absorption. They also study drug delivery systems, as well as various physical and pharmacological modalities to minimize the risk of systemic exposure to topically applied agents. Over-the-counter medications, prescription drugs and alternative therapies are studied because patients often present after having self-medicated. Instructors emphasize the diagnosis and identification of conditions that require therapeutic management and follow-up. At the same time, students learn the clinical application of topical and local anesthetics, ocular dyes and stains, mydriatics, cycloplegics and mydriolytics (miotics).

3.3 The College of Optometrists of Ontario

The Optometry Act, 1991 established the College of Optometrists of Ontario (COO) as the self-governing body for the profession of optometry. The College regulates 1,348 practising members in 220 communities around the province. To maintain registration in Ontario, optometrists are required to accumulate 60 hours of accredited education every three years. The continuing education requirement is designed to ensure that practising optometrists are aware of advancements in medical science and technology, and practice standards.[6]

4. Factors Informing HPRAC's Recommendation

4.1 Risk of Harm

TPAs are prescribed to treat eye diseases and disorders. They may be administered orally or topically. In its proposal, the OAO identified six pharmaceutical categories (or classes of drugs) that qualified members of the College could be competent to prescribe as part of a patient-treatment plan. They are:

---

[6] Submission to the Health Professions Regulatory Advisory Council by the Ontario Association of Optometrists, April 2005, pg 13

- anti-infective agents;
- anti-inflammatory agents;
- cycloplegic agents;
- anti-allergy agents;
- artificial tears, ocular lubricants and secretagogues; and,
- anti-glaucoma agents.

Within each category are several sub-categories.

Broad Pharmaceutical Sub-categories

The list of TPAs proposed by the OAO includes a number of pharmaceuticals within a single drug class that vary in their risk of systemic effects.

Safety Record

Medications administered topically can improve therapeutic efficacy by increasing drug concentration at the intended site with less chance of systemic side effects.[7] Eight jurisdictions in Canada grant optometrists the authority to prescribe, at a minimum, topical TPAs for ocular conditions. Since 1996, when Alberta first granted optometrists the authority to prescribe TPAs, its regulatory college has not reported a single concern or public complaint, demonstrating the practice to be safe. In fact, the public safety experience has been impressive in jurisdictions that have enacted legislation allowing optometrists to prescribe TPAs.

Drug Lists vs. Drug Classes

With the exception of physicians, Ontario limits professionals who share the controlled act of prescribing and dispensing to specific drugs that are named individually in profession-specific regulations. This has caused problems for some. For example, nurse practitioners and midwives have been prevented from using more economical pharmaceutical agents, with the same properties as those specifically appearing on their professions' drug lists, in the care of their patients. The same is true with respect to their ability to apply innovations in drug therapy. Even where a pharmaceutical has become recognized as the best-practice standard, protracted timelines associated with the process of obtaining approval of a regulation change, allowing for the use of a new drug by a non-physician practitioner, can mitigate against optimal care. Regulations that specify drugs by class, with suitable practice guidelines as instituted in other jurisdictions, is a preferable approach.

However, lack of toxicity associated with one member of a drug class does not necessarily ensure the safety of other members of that class in a given patient.[8] Clinical training and practice to develop the necessary expertise to select from within drug classes in relation to a specific patient is required.

---

[7] D. M. Grant, Ph.D., Department of Pharmacology, University of Toronto, *Risks of Prescribing Designated Therapeutic Pharmaceutical Agents by Optometrists*, February, 2006, pg 4.

[8] ibid. pg 24

Oral TPAs

Oral TPAs that target eye diseases or disorders have a higher chance of side effects in unintended locations such as the brain, heart, blood vessels, lungs, liver, kidneys or other body systems. They also present a greater risk of drug interactions with other medications that have been delivered systemically. The OAO's proposed list of orally administered drugs includes oral antibiotics, oral cholinergic agents, oral carbonic anhydrase inhibitors and oral hyperosmotic agents.

Two stakeholder groups, the Ontario Medical Association (OMA), and the Canadian Ophthalmologic Society (COS), disagree that optometrists have the appropriate training to manage the systemic effects and drug interactions that may be involved. In a policy statement on the use of TPAs by non-medical personnel, the COS states its position that only physicians have the knowledge of these different organs required to safely use such drugs.

For an independent opinion, HPRAC engaged an external expert to review the optometry curricula of the Universities of Waterloo and Montreal. His advice was that Canadian optometry students have sufficient didactic course teaching in basic principles of pharmacology to graduate with an understanding of the theory behind possible mechanisms of drug toxicity that are related to the systemic and ocular administration of the designated TPAs.[9] He urged expanded opportunities for clinical placements for students and adequate refresher courses for practicing optometrists.

Optometrists in seven Canadian provinces and in all fifty states in the United States prescribe oral, as well as topical, TPAs. Their experience demonstrates that optometrists from accredited programs, such as the Universities of Waterloo and Montreal, have the requisite knowledge and training to appropriately prescribe topical therapeutic pharmaceutical agents on the OAO-proposed list, with the exception of anti-glaucoma medications.

Anti-glaucoma Agents

Many of these agents, such as the adrenergic agonists and blockers, have been shown to be significantly absorbed into the systemic circulation following topical ocular application. Prescribing glaucoma medications for either topical or oral administration carries a level of risk beyond the use of other listed agents used for eye disorders, such as infections.[10] Moreover, oral hyperosmotic agents are given to glaucoma patients on an emergency basis and would not be prescribed by an optometrist in a clinic setting.

---

[9] ibid. pg 11.

[10] ibid. pg 12.

Consequently, HPRAC has found that prescribing drugs for glaucoma patients is better suited to a co-management arrangement between ophthalmologists and optometrists as is the practice in many Canadian jurisdictions. Because anti-glaucoma agents are prescribed on a long-term basis, they require regular follow-up appointments with the prescribing practitioner. Where frequent follow-up is needed and the consequences potentially severe (blindness), a co-management arrangement is the most reasonable approach. Under this arrangement, the consultant ophthalmologist takes the lead while the optometrist monitors visual acuity, intraocular pressure, optic disc appearance and visual fields.[11]

4.2 Health Human Resources

Health human resource studies indicate that there is a growing shortage of family physicians in Ontario.[12] While recent government action may reduce this trend somewhat, it remains a public policy concern. At the same time, trends in ophthalmology practice indicate that the majority of ophthalmologists are focusing on surgical care rather than medical services. A 2004 College of Physicians and Surgeons of Ontario study indicates that fewer medical graduates are choosing family medicine and that a significant number of medical specialists, such as ophthalmologists, are approaching retirement age. Several studies attest to these trends.

This trend is in sharp contrast to the increasing supply of optometrists.[13] Between 1993 and 2002, the number of active registered optometrists in Ontario increased to 1,258 from 885. The College of Optometrists of Ontario currently regulates 1,348 practising members in 220 communities. The number of active registered optometrists per 100,000 population rose to 10.4 in 2002 from 8.2 in 1993. In comparison, the national number stood at 11.4 per 100,000. It may be that Ontario is losing recent optometry graduates to locations where they completed clinical externships because of Ontario scope of practice restrictions that are not found in other provinces.

The profession of optometry has a national labour mobility agreement that allows reciprocity for practice in other jurisdictions in Canada without unnecessary barriers. The Ontario Association of Optometrists notes that the lack of authority to prescribe TPAs has made Ontario a less desirable practice location for recent graduates and for optometrists looking to relocate.

These developments support an expanded vision-care role for optometrists to offset pressures occurring elsewhere in the health care system.

---

[11] CE Willis; SJA Rankin; AJ Jackson, *Glaucoma in Optometric Practice: A Survey of Optometrists*, Ophthal. Physiol. Opt. Vol 20(1): 70-75, 2000.

[12] College of Physicians and Surgeons of Ontario, *Tacking the Doctor Shortage: A Discussion Paper*, May 2004.

[13] Canadian Institute for Health Information, "Health Personnel Trends in Canada, 1993-2002" 2004.

4.3 Capacity-Building

As a result of trends in physician supply, there is an increasing need for qualified non-physicians to provide care in certain circumstances. By authorizing appropriately trained optometrists to expand the services that they provide to patients, several benefits will result. They are:

- increased access, convenience and choice for health care consumers;
- workload and potential wait-time reductions for other professionals, specifically, ophthalmologists and family physicians; and
- reduction in duplication of appointments that result from referrals to other health professionals solely to obtain a medication prescription.

With implementation, patients who require ocular medications would have the option of receiving treatment from a family physician, optometrist, or ophthalmologist in an office or clinic setting or in an emergency department. Enhanced access for patients to a qualified health care provider of their choice generally improves the system's accountability to the public.

4.4 Proficiency

When deciding to prescribe, the clinician must weigh the possible risk of drug treatment and conduct a risk-benefit analysis of the failure to treat the disorder compared with the benefits of a successful treatment.[14] It is essential to understand the likelihood of possible side effects, drug interactions, contraindications and correct dosing regimen to obtain the desired result in the safest manner possible when prescribing any therapeutic pharmaceutical agent.[15]

HPRAC reviewed numerous submissions regarding the proficiency of optometrists to competently prescribe TPAs. Some vouched for the skills of Ontario's optometry practitioners. Others were less convinced. Based on the evidence, the Advisory Council accepts that optometrists in Ontario have the requisite knowledge, training and education upon graduation, to appropriately prescribe therapeutic pharmaceutical agents with the exception of anti-glaucoma medications.

4.5 Collaborative Practice

Granting optometrists the authority to prescribe therapeutic pharmaceutical agents is aligned with the Ministry of Health and Long-Term Care's Transformation Strategy with a focus on increasing access to health care services. Currently, optometry patients requiring eye medications are referred to a family physician or ophthalmologist to obtain a prescription. Allowing optometrists to prescribe TPAs would eliminate this step and allow patients to obtain prescriptions during their visit with the optometrist.

---

[14] D.M. Grant, Ph.D., Dept. of Pharmacology, University of Toronto, *The Risks of Prescribing Designated Therapeutical Pharmaceutical Agents by Optometrists*, February, 2006, pg 3.

[15] Gregory S. Black; Julie A Tyler; Alan G Kabat, *The Role of Oral Medications in Optometry*, Review of Optometry, 2005.

The recommendation to permit optometrists to prescribe topical TPAs has the support of the Ontario College of Family Physicians, indicating a willingness to work collaboratively with optometrists at the community level.

5. Summarizing the Case for Optometrists Prescribing TPAs

As a result of its analysis, HPRAC is convinced that optometrists should be permitted limited prescribing rights with respect to TPAs. The following facts support this.

- Optometry programs at the universities of Montreal and Waterloo are accredited by the Accreditation Council of Optometric Education. In this instance, accreditation of the academic institution permits graduates of these programs to practice anywhere in North America including jurisdictions where optometrists are authorized to prescribe TPAs.

- An independent expert agrees that there is sufficient education on the principles of pharmacology being offered in schools of Optometry for graduates to be proficient in recognizing possible drug interactions and toxicities related to the use of TPAs as part of the treatment of conditions of the eye.

- That same expert recommends additional clinical training for student optometrists and further clinical experience or skills upgrading for current practitioners.

- By allowing optometrists to prescribe TPAs, opportunities for clinical placements in Ontario should increase over time.

- HPRAC's jurisdictional review of provinces and territories where optometrists are authorized to prescribe TPAs failed to find any evidence of patient complaints or safety issues.

- A PriceWaterhouseCoopers study on the use of TPAs by optometrists in California concluded that optometrists practice therapeutics with at least the same level of competence as primary care providers and ophthalmologists managing the same problems.

- Anti-glaucoma treatments do represent a special case. The Advisory Council is convinced that these medications should only be administered as part of a co-management arrangement between an optometrist and an ophthalmologist where the ophthalmologist is the recognized primary care giver.

Broadening the scope of practice for optometrists by permitting limited use of TPAs will provide more access to care for Ontarians, make Ontario a more attractive location for optometrists to practice, and help address some of the physician-supply problems in the province. It also supports the province's focus on multi-disciplinary teams and collaborative care.

6. Transition

The *RHPA* has several objectives, including accountability of regulated health professions to the public. Accountability is maintained through the controlled acts system, the procedural code, and profession-specific acts which establish proficiencies for a profession and provide recourse for patient grievances.

HPRAC's central recommendation is that optometrists in Ontario be authorized to prescribe therapeutic pharmaceutical agents, with the exception of anti-glaucoma medications.

To responsibly give effect to this recommendation, the College of Optometrists of Ontario must develop standards of practice and practice guidelines to ensure appropriate accountability measures are in place. Part of this process involves identifying the current qualifications of members to prescribe as well as any educational or bridging programs that are necessary.[16]

6.1 Establishing Qualifications

Prior to 1995, the University of Waterloo did not require students of Optometry to participate in the clinical therapeutics externship. The College of Optometrists of Ontario estimates that 25 percent of members either graduated before 1995 or have not taken a 100-hour refresher course in prescribing TPAs.

Because educational upgrading will be necessary for roughly one quarter of its members, the College will have to "impose terms, conditions and limitations" on certificates of registration for those members who have not had appropriate training in prescribing.

6.2 Educational Upgrading

The College would also have to develop educational upgrades and bridging programs for the following groups:

- Graduates prior to 1995;
- Graduates post-1995; and,
- Optometrists who prescribe TPAs in another jurisdiction and transfer to Ontario.

The typical length of education programs in other jurisdictions is 100 hours of combined didactic and practical training to achieve competency in the treatment of ocular conditions with TPAs.

---

[16] D.M. Grant, Ph.D., Dept. of Pharmacology, University of Toronto, *Risks of Prescribing Designated Therapeutic Pharmaceutical Agents by Optometrists*, February 6, 2006, pg 11.

6.3 Ongoing Proficiency

The vast majority (75 percent) of optometrists in Ontario have the requisite knowledge, training and education to appropriately prescribe therapeutic pharmaceutical agents. Still, it will be important to refresh members' knowledge and skills in light of the pace of developments and innovations in pharmacology.[17] Therefore, HPRAC expects that the College of Optometry of Ontario will set education requirements to ensure continuing competence.

6.4 Prescription Verification

Along with an additional authority to prescribe, optometrists will have new responsibilities, in particular, to provide after-hours support to patients regarding the prescription. The prescribing health professional must also be available for consultation with a pharmacist if necessary on an after-hours basis. The College of Optometry of Ontario will have to develop guidelines for its members on this matter.

6.5 Collaborative Practice

HPRAC recommends that the College of Optometrists of Ontario work with the College of Physicians and Surgeons to develop practice guidelines and information programs for collaboration in patient care.

6.6 Health System Costs

The OAO does not anticipate significant change in costs to the province because annual eye exams for healthy adults are no longer an insured service under OHIP. Based upon the change to OHIP insured eye care services in effect since November 2004, any potential increase in fees charged by optometrists may impact either the patient directly or private health insurance plans.

7. Recommendations

HPRAC recommends to the Minister:

1. That Ontario optometrists be granted the authority to prescribe therapeutic pharmaceutical agents with the exception of anti-glaucoma medications.

2. That *The Optometry Act, 1991* be amended by adding the following to section 4(4): Prescribing drugs in the categories of drugs as prescribed by regulation.

3. That the Council of the College of Optometrists of Ontario make regulations, subject to approval of the Lieutenant Governor, and with prior review of the Minister, prescribing the categories of drugs to be prescribed.

---

[17] Ibid, pg 12.

4. That subsequent to any legislative change, and to support its successful implementation, the College of Optometry of Ontario:

    1. Establish new practice and proficiency standards and guidelines for its members;

    2. Establish educational upgrading and bridging programs for members;

    3. Impose "terms, conditions and limitations" on certificates of registration for those members who have not had appropriate training in prescribing until the requisite proficiency had been achieved; and

    4. Undertake with the College of Physicians and Surgeons of Ontario the development of joint guidelines respecting co-management of glaucoma patients, referrals and other matters relating to collaboration between the two professions.

REGULATION OF PHARMACY TECHNICIANS

The Minister's Question

On February 7, 2005 the Minister of Health and Long-Term Care requested advice from the Health Professions Regulatory Advisory Council (HPRAC) on,

> Whether pharmacy technicians/assistants should be regulated under the RHPA, including what their scope of practice should be, what controlled acts, if any, they should be authorized to perform, and any protected titles.
>
> Additionally, whether it is appropriate that pharmacy technicians be regulated under the Pharmacy Act, 1991[1]

HPRAC's Response

HPRAC's central response is that pharmacy technicians should be regulated as a class in the Ontario College of Pharmacists.

1. History of the Referral

The Ontario College of Pharmacists (OCP) has requested the creation of a new class of pharmacy practitioner under the *Pharmacy Act* and the *Regulated Health Professions Act, 1991* – the Registered Pharmacy Technician (R PH.T.). This new class of pharmacy practitioner will be fundamentally distinct from those individuals currently working in Ontario in pharmacies.

The OCP proposal has evolved directly from *Prescriptions for Health: Report of the Pharmaceutical Inquiry of Ontario* (known as the Lowy Report, 1990). The report describes the two main responsibilities of the pharmacist:

1. Cognitive, patient-oriented activities such as consulting with prescribers, patients and other health care professionals to optimize drug therapy.

2. Product-related responsibilities of acquiring, storing, labelling, packaging, dispensing of drugs, and record keeping associated with this work.

The Inquiry determined that major changes were needed in the role of the profession of pharmacy, and that pharmacists were not meeting their potential as members of the health care team whose objective is to ensure optimum drug therapy. The report said that:

---

[1] Minister's Referral Letter, February 2005, Appendix A

> …Ways must be found for pharmacists to provide more comprehensive patient-oriented services, including maintenance of medication and drug allergy profiles, monitoring of drug therapy, patient counselling, public drug education, provision of drug services to home care patients, drug utilization review programs, health promotion, self-care consultation services (non prescription drug counselling, health care aids) and drug information and consultative services to other health care professionals.

The report also indicates:

> …That the proper deployment of non-professional personnel, such as pharmacy assistants, requires careful consideration. While pharmacists retain final responsibility for the drug dispensed and sold, the use of auxiliary personnel in this process has become significant. Such personnel can relieve the pharmacist of many of the technical or repetitive operations inherent in the product-oriented parts of practice, freeing time for more patient-oriented tasks.

Dr. Lowy further recommended that:

> …The Ontario College of Pharmacists clearly define the respective roles of auxiliary personnel and pharmacists and ensure that assistants perform technical, product oriented tasks while pharmacists concentrate on patient-oriented tasks such as monitoring drug therapy and providing advice on drugs to patients and other health care professionals. The strategies used to ensure this implementation should be associated with the promulgation of standards of practice and competence assurance.

To this end, the report recommended that:

> …The faculties of medicine and pharmacy at the University of Toronto jointly instruct students in patient-oriented services, including choice of drug therapy, monitoring techniques and patient counselling.

1.1 Interim Steps

Since the Lowy Report, the OCP has worked to implement its recommendations through a variety of means.

1. *Collaborative Practice* – The OCP established a *Task Force on Optimizing the Role of the Pharmacist* to develop guidelines and protocols which expand the role of pharmacists, including collaborative arrangements with physicians in the areas of documentation, sharing of patient records and consulting. Under these protocols, an expanded role for pharmacists would also include: performance of medication reviews; obtaining refill authority for chronic therapy; and monitoring of patient therapy and adjustment of doses in collaborative practices. A new and accountable role for independent pharmacy technicians is pivotal to the implementation of an expanded role for pharmacists.

2. *Educational Standards* – The OCP participated with the Ontario Colleges of Applied Arts and Technology in creating a formal education program for pharmacy technicians. Today, ten community colleges in Ontario offer Ministry of Training, Colleges and Universities' accredited diploma programs, and nine career colleges in twenty-seven locales offer training programs. Training may also take place on-the-job in accredited pharmacies and hospitals.

3. *Voluntary Certification* – In 1997, OCP launched the Pharmacy Technician Working Group with representation and input from pharmacy technicians. The group developed standards of practice and a code of conduct for a voluntary pharmacy technician certification program, defined skill sets for certified pharmacy technicians and introduced certification examinations.

   Successful completion of the program provides candidates with documentation that they have demonstrated the essential job skills as outlined in *Guidelines for the Pharmacist on the Role of the Pharmacy Technician* (OCP, 1994). It also gives them the right to use the designation Certified Pharmacy Technician - C.Ph.T.. In some practice settings, being a Certified Pharmacy Technician has become a condition of employment. It is estimated that 2,500 pharmacy technicians have been certified since the program was introduced.

2. Current Proposal

The College has since submitted a request to the Minister of Health and Long-Term Care that a new regulated class of pharmacy practitioner be introduced, with specific entry to practice requirements, scope of practice and accountabilities under the *Regulated Health Professions Act, 1991*. Registered pharmacy technicians would be distinct and different from certified technicians, with different education and responsibilities. This proposal is endorsed by the Canadian Association of Pharmacy Technicians and the Ontario Pharmacists' Association.

The OCP proposes that registered pharmacy technicians would work collaboratively with pharmacists. These technicians would be professionally accountable for a number of the technical pharmacy dispensing services that are currently included solely within the scope of practice of pharmacists.

3. The Consultation Process

HPRAC requested a submission from the Ontario College of Pharmacists in response to a detailed questionnaire, and invited written submissions from regulated health professional colleges, health professional associations, consumer organizations, industry associations and individuals wishing to comment. Seventeen organizations and 31 individuals responded. These were supplemented with nine stakeholder consultations, including seven focus groups with pharmacy technicians, one with members of the Ontario Chain Drug Stores Association, and one with consumers. A number of key informant interviews followed, along with discussions with a health law policy expert.

The process was made accessible to Ontario pharmacists through an internet survey that drew responses from 369 pharmacists, and while not statistically valid, provided HPRAC with an opportunity to test understanding and other matters relating to the proposal, and to identify new issues for analysis. Site visits provided an overview of pharmacies, and opportunities to observe technicians and other auxiliary personnel working together in three settings: the University Health Network Pharmacy Department in Toronto, a community pharmacy, and a chain drug store. The consultations were further informed by additional discussions and clarification of issues with the Ontario College of Pharmacists.

It was also necessary to consider several related pieces of federal and provincial legislation in the course of HPRAC's review of the question.

4. Background

"The practice of pharmacy is the custody, compounding and dispensing of drugs, the provision of non-prescription drugs, health care aids and devices and the provision of information related to drug use."
Pharmacy Act, 1991, c. 36, s.3

4.1 Pharmacy Technicians in Accredited Pharmacies

Under the *Drug and Pharmacies Regulation Act (DPRA)*, only a pharmacist in an accredited pharmacy may dispense drugs, and pharmacy technicians work under the direction and supervision of pharmacists in technical aspects of that work. Training and level of responsibility assigned in day-to-day operations distinguish them from other auxiliary pharmacy personnel such as pharmacy assistants or counter assistants.

At present, pharmacy technicians perform a number of functions. They may receive written prescriptions; establish and maintain patient profiles; perform clerical activities related to billings, receipts, invoices and filing; generate long-term care data (medication administration records, medication reviews); retrieve, count, pour, weigh, measure, mix, and reconstitute medications; prepare intravenous mixtures, parenteral solutions, chemotherapeutic agents requiring aseptic technique and specialty products; prepare prescription labels, select type of prescription container and affix prescription and auxiliary labels, repackage and label medications; price and file prescriptions; perform inventory management tasks; replenish medications for nursing units, night cupboards, emergency boxes and cardiac arrest kits; and maintain packaging and dispensing equipment.[2]

4.2 Pharmacy Technicians in Hospitals

Dispensing drugs in hospitals and other licensed institutions is exempt from provisions of the *DPRA*. Pharmacists in such settings may delegate the technical components of dispensing and compounding to a pharmacy technician.

---

[2] College of Pharmacists, Request for Regulation of Pharmacy Technicians, April 2005

Hospital operations typically involve the pharmacist in patient-care medical teams leaving less time available for work in the dispensary. This, coupled with high vacancy rates in hospital pharmacist positions across Canada, has meant that hospital pharmacy technicians have taken on greater responsibilities in dispensing.[3]

In this situation, the pharmacist may be involved only to screen the prescription against the patient's profile, verify the medication order as entered, and provide clinical services. As a template for the competent performance of these duties, The Canadian Society of Hospital Pharmacists (CSHP) published guidelines and objectives for hospital pharmacy technician training programs.

4.3 Community-Based Sector

In the community, consumers may encounter pharmacy technicians working at a drug store chain, a department or grocery store. All venues must be accredited pharmacies in accordance with the *Drug and Pharmacy Regulation Act*. In these settings, the *DPRA* only permits the pharmacist to dispense drugs.

Apart from this restriction, the role of the pharmacy technician in community practice tends to be less structured than in an institutional setting. There can be significant differences from store-to-store, or from shift-to-shift within a single locale. There may also be disparities between technicians in any given pharmacy.[4]

4.4 Education and training

At present, it is estimated that there are approximately 20,000 auxiliary personnel in Ontario working as unregulated pharmacy technicians under the supervision of a retail pharmacist or under delegation in the hospital sector.

Many respondents expressed concern that education, training and other standards for this group of individuals is not standardized, and that competencies are not consistent from place to place. For example, diploma programs offered by career colleges may be substantially different from community college programs. As a result of this variation in training, by the mid-1990s the workplace employed pharmacy technicians with disparate knowledge, training and skills.[5] This situation prompted the OCP to establish the voluntary certification program.

The Ontario Hospital Association, in its submission to HPRAC[6], noted that from a patient safety perspective, regulation would provide standardized entry-level educational requirements and scope of practice competencies.

---

[3] Canadian Pharmacists Association., Environmental Scan of Pharmacy Technicians, 2001
[4] Ibid, pg 5
[5] College of Pharmacists, Request for Regulation of Pharmacy Technicians, April 2005
[6] Ontario Hospital Association, Submission to HPRAC, June, 2005

> To perform the delegation of dispensing and compounding tasks, many hospitals require Technicians to have proof of completion of a formal training program at the college level. Currently, no standardized training for Pharmacy Technicians exists. Recently, many hospitals have added the OCP Pharmacy Technician certification process to hiring standards. Regulation of Pharmacy Technicians will require that education programs will have to meet minimum standards.

4.5 The Canadian Association of Pharmacy Technicians

The Canadian Association of Pharmacy Technicians (CAPT) has chapters in Alberta, Manitoba, Nova Scotia and Ontario. Its 300 members working in this province have a variety of educational and training experiences at colleges, training facilities, and in-service. CAPT's goal is to facilitate communication and information exchange between all technicians and provide information on employment opportunities.

CAPT does not have a formal complaints or disciplinary procedure. It receives an insignificant number of complaints from the public each year and refers the complainant to the appropriate regulatory body.[7]

5. Ontario College of Pharmacists Proposal

5.1 The Proposal

The Ontario College of Pharmacists proposes that pharmacy technicians be regulated under the *Pharmacy Act*, as Registered Pharmacy Technicians (R.Ph.T.), members of the Ontario College of Pharmacists in the Pharmacy Technician class. R.Ph.T.'s would be qualified to perform an expanded roster of duties and be accountable for their work. This would enable Pharmacists to focus on therapeutic issues by relieving them of some technical aspects of dispensing prescription orders.[8]

The proposal notes the variety of educational backgrounds and training of pharmacy technicians, and that

> However the pharmacy technician is educated or trained, current legislation does not recognize Pharmacy Technicians; they have no defined scope of practice, standards of practice, or code of ethics, nor are they accountable to the public through OCP for their practice. Their role is limited to those tasks listed in *Guidelines for the Pharmacist on the Role of the Pharmacy Technician* (OCP, 1994).[9]

---

[7] Ibid, pages 55, 57 and 64

[8] College of Pharmacists, Request for Regulation of Pharmacy Technicians, April 2005

[9] College of Pharmacists, Request for Regulation of Pharmacy Technicians, April 2005

A Pharmacist would continue to have responsibility for overall supervision of the pharmacy premises and to perform his or her patient centred role in preventing, identifying and solving drug related problems.

The R.Ph.T. would have no authority to perform services separate from or outside of a pharmacy or without the presence of a Pharmacist in an accredited pharmacy setting, as required under the *DPRA*.

Concurrent to this proposal, OCP also seeks changes to the *DPRA* to enable R.Ph.T.'s to compound and dispense drugs in accredited pharmacies. In hospital pharmacies, the R.Ph.T. would provide the technical services independently, within the monitoring and quality control procedures of the hospital. In all instances, the Pharmacist would provide patient counselling services and final verification of the prescription.

The College has recommended a competency profile for pharmacy technicians, along with proposed standards of practice for registered pharmacy technicians. It is currently revising its code of ethics to take into account pharmacy technicians. Together, these will define the role of the Regulated Pharmacy Technician and describe the added services they will provide such as:

- Receiving a new or repeat prescription from authorized prescribers;
- Transferring prescriptions to, and receiving prescriptions from, other pharmacies;
- Copying prescriptions for authorized recipients;
- Checking pharmaceutical products prepared by another R.Ph.T. or by unregulated pharmacy personnel;
- Confirming the accuracy and completeness of pharmaceutical products prepared for release; and
- Referring all inquiries and/or issues that require a therapeutic decision to the Pharmacist.

The practices of dispensing and compounding authorized to a pharmacy technician would differ from that of a pharmacist. R.Ph.T.'s would be limited to technical aspects of performing these controlled acts.

The OCP has described the technical components of dispensing and compounding in pharmacy practice in the publication *Protocol for Delegating Dispensing and Compounding in Health Care Facilities* as:

- Receiving a written prescription;
- Interpreting (i.e., reading) a prescription;
- Adjusting an order according to an approved policy (e.g., therapeutic interchange in hospitals);
- Order entry;
- Selecting the drug (i.e., determining product to dispense);
- Reconstituting a product;
- Determining expiry date of product;
- Repackaging medications (into vial, unit-dose package, syringe);
- Labelling a product;
- Final physical check for accuracy of finished product;
- Maintaining (not interpreting) patient profiles; and
- Maintaining, preparing and operating equipment.

Drugs which may be compounded include extemporaneous non-sterile topical and oral preparations as well as IV admixtures and other sterile preparations. The technical tasks within "compounding a drug" are:

- Selecting ingredients;
- Performing calculations of quantities;
- Determining equipment to be used;
- Physically preparing product according to approved formula and protocol;
- Carrying out established quality control assessments on product; and
- Final physical check of finished product.

Registered Pharmacy Technicians would be limited in the pharmacy information they provide to patients. The OCP's *Proposed Standards of Practice for Registered Pharmacy Technicians* specifically describes when the Pharmacy Technician must refer to a Pharmacist (for example, the provision of clinical or therapeutic information).

5.2 New Proficiencies

The OCP proposal recognizes that the technical aspects of compounding and dispensing that would be authorized to R.Ph.T.'s would require new skills and proficiencies, and that this knowledge would distinguish registered pharmacy technicians from other pharmacy personnel.

The R.Ph.T. would assume new distributive and quality assurance responsibilities, which include: selecting task-appropriate technology and using it effectively, applying expertise in infection control procedures, ensuring the safe performance of high-risk activities, executing error reduction and prevention processes, implementing procedures for the removal/ disposal of drugs, auditing, carrying out inventory management, and developing, implementing and evaluating quality indicators. The R.Ph.T. would also work with pharmacy management to identify staffing requirements and schedule personnel.

The R.Ph.T. would be accountable for maintaining confidentiality of patient information gained when documenting demographic and prescription data and other pharmacy-related information in the patient file or health record. Additionally, the R.Ph.T. would need proficiency in the recognition of therapeutic issues to refer them to the pharmacist.

6. Complexity of the Proposal

In its consideration of the proposal, HPRAC was aware that OCP had taken significant steps to support an enhanced professional role for pharmacists through an evolving process of increasing skills of auxiliary personnel.

For HPRAC, the complexity of the OCP request for regulation of pharmacy technicians was compounded by three factors:

1. OCP had created a "certified pharmacy technician" program that was distinct from its proposal for "registered pharmacy technicians", and some uncertainty or confusion existed as a result;

2. Educational programs required for implementation of the R.Ph.T. registration were not yet in place, and were unlikely to be put in place unless the government moved forward with the regulation of pharmacy technicians; and

3. Pharmacy technicians are currently authorized by law to perform different tasks depending on whether they work in an accredited pharmacy or in an institutional setting.

7. Factors Informing HPRAC's Recommendation

7.1 Regulation or Delegation

HPRAC considered the merits of regulation of pharmacy technicians as an independent professional class versus delegation by pharmacists of some dispensing duties. Some stakeholders suggested that certification of pharmacy technicians could be strengthened, and aspects of dispensing delegated to certified pharmacy technicians. This would entail a change to the *DPRA*.

> …We feel that delegation strikes the right balance between freeing up pharmacists from basic technical tasks for other activities, and assuring continued public confidence in pharmacy services. In addition, the delegation model is more precise in its application and, for example, can distinguish between complex and simple compounding (e.g. individualized cancer medications versus mixing an active ingredient into a cream). The registration of pharmacy technicians as independent practitioners would not permit this type of distinction.
>
> Ontario Medical Association[10]

Most who commented on the proposal, however, expressed the opposite point of view. For example:

> Dispensing drugs carries with it a risk of harm that warrants the full regulatory provisions that regulation under the *Regulated Health Professions Act* provides.
>
> College of Dieticians of Ontario[11]

Following extensive analysis, HPRAC notes that delegation does not provide a mechanism to address issues in the delivery of pharmacy services including:

1. *Accountability* – In HPRAC's view, delegation alone would not ensure quality dispensing services in accredited pharmacies or sufficient accountability for pharmacy technicians.

2. *Standards of Practice* – Within the current environment, pharmacy technicians are differently qualified. Delegation does not address the issue of consistent competencies.

---

[10] Submission to HPRAC, June, 2005

[11] Submission to HPRAC, College of Dietitians of Ontario, June, 2005

HPRAC concluded that regulation addresses the deficiencies of the delegation option, and provides for better quality of care and enhanced patient safety across the entire pharmacy sector.

Regulation would also provide the College with additional ability to monitor the quality of performance and competence of pharmacy technicians in all pharmacies in Ontario. Patients and customers would have a complaints mechanism available to address problems with the professional who dispensed their drugs. Regulation would also ensure consistent competency and entry to practice requirements.

HPRAC concluded that regulation will contribute to a higher and consistent level of patient safety and service delivery across the entire pharmacy sector in Ontario in retail, hospital and institutional settings. Regulation of pharmacy technicians will enable pharmacists to collaborate more with others providing professional services, including prescribers, which should add to the quality of patient care.

7.2 Risk of Harm

There is general recognition that a risk of harm to patients is inherent in the act of compounding and dispensing of drugs (a controlled act under the *RHPA*).

A specific risk of harm to patients brought to HPRAC's attention in the course of its review of the regulation of pharmacy technicians merits discussion:

Verbal Prescriptions

Verbal prescriptions or medication orders are prescriptions that are communicated or changed through oral discussion either in person or by telephone. That is, verbal prescriptions are not in writing. The United States Pharmacopoeia Medication Errors Reporting program concludes that confusion over the similarity of drug names accounts for approximately 25 percent of drug errors. Verbal prescriptions are a significant factor in such medication errors.

The National Coordinating Council for Medication Error Reporting and Prevention in the United States therefore has made important recommendations[11] regarding verbal prescriptions and medication orders as discussed in HPRAC's Legislative Framework report. The Canadian Society of Hospital Pharmacists (CSHP) has also published guidelines.

The need for protocols was underlined by many respondents, who questioned whether regulated pharmacy technicians should be permitted to receive verbal prescriptions:

---

[11] ©NCCMERP, Council Recommendations, February 20, 2001

> Receiving verbal prescriptions is an activity that can and should be questioned. Most health professionals assert that this practice is to be avoided because of the potential for inaccuracy of any verbal prescription. This may need to be clarified, or restricted to verbal clarification of a written order.[13]
>
> Humber School of Health Sciences

Cancer Care Ontario recommended to HPRAC that only a pharmacist and not a pharmacy technician receive telephone or verbal orders related to antineoplastic drugs, in consideration of safe care regarding these highly toxic preparations. The Ontario Hospital Association expressed its concerns that giving responsibility for taking verbal prescriptions to a pharmacy technician could potentially put patients at risk.

The Canadian Association of Chain Drug Stores references the American Society of Hospital Pharmacists' guidelines[14] in this regard:

> According to the ASHP to prevent errors only physicians, pharmacists and nurses should be permitted to dictate and receive verbal prescriptions and orders. In many cases, discrepancies are subtle and may not be readily apparent; even to the most experienced practitioners…
>
> …The potential for error is increased due to the reliance on memory and the variances in individual communication skills/pronunciation. Queries by other health providers regarding therapeutic aspects of an individual's profile often can seem unimportant or trivial during an exchange, so that it may be difficult for a technician to distinguish if indeed a pharmacist should be involved in the exchange. Guidelines that have been established to help eliminate errors and enhance patient safety surrounding verbal orders include limiting the number of practitioners permitted to receive verbal orders. The proposed enhanced role and standards for technicians seems to disregard these guidelines and in doing so, may jeopardize patient safety.

HPRAC notes that patient safety may be endangered through verbal prescriptions and medical orders whether it is the pharmacist or the pharmacy technician who is receiving the order, and should be discouraged. In an electronic era, it is difficult to understand why the practice continues other than in cases of extreme emergency. Significant risk of harm was found to be present in the communication and completion of verbal prescriptions. To address this matter, HPRAC recommends:

> **That regulations under the *Pharmacy Act* specify that receiving verbal prescriptions is not approved for registered pharmacy technicians.**

---

[13] Submission to HPRAC, June, 2005
[14] American Society of Hospital Pharmacists, Am J Hosp Pharm, 1993

As discussed in the Legislative Framework recommendations, HPRAC further recommends:

> **That the Minister issue a direction specifying that protocols surrounding verbal prescriptions should specifically be addressed, individually and jointly, by the Ontario College of Pharmacists and other regulatory colleges whose members are authorized to prescribe medications: College of Physicians and Surgeons of Ontario (CPSO); Royal College of Dental Surgeons of Ontario (RCDSO); College of Nurses of Ontario (CNO); and College of Midwives of Ontario (CMO).**

Collaborative guidelines for verbal prescriptions or medication orders should consider:

- limiting verbal prescriptions to the greatest extent possible;
- electronic transmissions to confirm verbal prescriptions;
- identifying situations where there is high risk of harm, such as in the case of certain classes of drugs (such as antineoplastic drugs) and development of appropriate strategies to address these situations;
- identifying the professionals who should be able to make verbal medication orders.

7.3 Qualifications

HPRAC agrees with the OCP that in order to successfully fulfill new functions and responsibilities, regulated pharmacy technicians will need to call on a distinct body of knowledge with specific educational and training requirements and certification examination. An educational program for regulated pharmacy technicians is not yet available in Canada – education programs for pharmacy technicians will need to be developed to meet OCP entry to practice requirements. To this end, the OCP has committed to working with other licensing bodies across Canada, and with the Ontario Ministry of Training, Colleges and Universities to establish the specific education, practical training, examination and registration requirements.

Issues to consider include:

1. *Body of Knowledge* – The OCP has integrated a core body of knowledge into its *Competency Profile for Pharmacy Technicians* and *Proposed Standards of Practice for Registered Pharmacy Technicians*. Regulation would allow OCP to further refine these requirements.

2. *Education Programs* – Community colleges familiar with the OCP's initiatives concur that the education programs leading to practice as a registered pharmacy technician will be considerably enriched compared to the existing pharmacy technician programs, and have yet to be developed. This process should be expedited as accredited providers know each other through Health & Sciences Heads and Heads of Pharmacy Technicians Programs professional networks set up by the Ministry of Training, Colleges and Universities. The OCP cannot rely on other Canadian provinces to provide this

educational program, as no other province has reached the point of regulating pharmacy technicians.

3. *Entry-to-Practice Exam* – OCP is working with the Canadian Council for Accreditation of Pharmacy Programs and the Canadian Pharmacy Technician Educators Association to explore development of national competency standards and educational outcomes for accreditation of pharmacy technicians across Canada. OCP anticipates partnering with the Pharmacy Examining Board of Canada to develop a voluntary, national certification exam for pharmacy technicians in Canada.

4. *No Grand-parenting* – As these requirements will be fundamentally different from and more advanced than the education and qualifications currently held by pharmacy technicians, there would be no automatic grand-parenting of existing pharmacy technicians into the new classification. Instead, those currently working in the field (C.Ph.T.'s and others) would be encouraged to upgrade their education as necessary, and would be required to pass the qualifying examination in order to practice as an R.Ph.T.

OCP estimated to HPRAC that it would be able to establish educational outcomes, an accreditation process and accreditation standards within a two year period. It has outlined a process for the development of prior learning assessments and educational bridging programs. HPRAC is satisfied that the educational program requirements will be met and qualified practitioners ready for entry to practice coincidental with proclamation of new legislation.

HPRAC also comments that in the event that regulation of pharmacy technicians does not move forward, steps taken to accrediting educational programs and facilities and establishing new curricula will likely cease.

7.4 Supervision

Since registered pharmacy technicians would be a new profession under the *RHPA*, HPRAC cannot comment on whether they are adequately supervised at present. In addition, given the range of work settings with differing legal requirements and a variety of employer policies, HPRAC is unable to ascertain whether unregulated pharmacy technicians today are sufficiently supervised in all places at all times. HPRAC has been told that significant numbers of unregulated pharmacy technicians do not have the quality of their performance monitored effectively by supervisors who are themselves regulated professionals.

This is anecdotal information, but HPRAC is convinced that regulation as a profession would entail the individual accountability of competent regulated pharmacy technicians for the performance and quality of their work. In addition, regulation of pharmacy technicians would provide the College with a new mechanism to monitor the quality of performance in all work settings.

7.5 Willingness of Practitioners to be Regulated

Ontario's Pharmacy Technicians have not sought regulation as a separate College under the *Regulated Health Professions Act, 1991* but instead have endorsed the OCP proposal that regulated pharmacy technicians be included as a class in the *Pharmacy Act.* The executive and members of the Ontario branch of the Canadian Association of Pharmacy Technicians have been involved in the OCP initiative to regulate the profession in Ontario, and have participated in committees to develop various components leading to regulation.

Pharmacy technicians have two well established associations: the Canadian Association of Pharmacy Technicians, which exists as a professional association for pharmacy technicians, and the Ontario Pharmacists Association.

The OCP points to the growing interest in its voluntary certification program as evidence of a commitment to ensuring a higher level and quality of health care, and a willingness to be regulated. Until the education and bridging programs are established however, it is difficult to determine the number of current pharmacy technicians that will opt for the registered pharmacy technician designation.

7.6 Human Resources

Creating a new class of pharmacy practitioners can help to relieve mounting pressures on the health care system.

- In 2000, the Canadian Pharmacy Association, together with Human Resources Development Canada, tabled *A Situational Analysis of Human Resource Issues in the Pharmacy Profession in Canada.* The report confirmed a national shortage of pharmacists and urged further study into the expansion of functions performed by pharmacy technicians as a means of offsetting impacts of pharmacist supply trends. HPRAC heard that employers may opt to hire more registered pharmacy technicians to supplement the work of pharmacists in areas where it is difficult to find pharmacists to meet community need.

- The declining supply of physicians creates another pressure on the health system. Expansion of collaborative health care teams can offer some relief, but there is a need for pharmacists to shift the focus of their practice from technical and administrative duties to take on an expanded role elsewhere. A new role for registered pharmacy technicians will permit pharmacists to accept an extended role in the community as active and collaborative partners in family care teams.

During the consultation phase of the Advisory Council's investigation, some expressed dismay that, in the early years, the supply of registered pharmacy technicians would fall short of demand in Ontario and across Canada. In this regard, HPRAC notes that the College of Pharmacists of British Columbia is also taking steps with the Pharmacy Examining Board of Canada to seek an examination for regulated pharmacy technicians.

HPRAC heard that other Canadian jurisdictions are moving in this direction as well. With national standards being proposed or considered in several Canadian provinces, individuals trained in other jurisdictions would be eligible to apply to practice in Ontario.

During the Advisory Council's consultations, concerns were expressed that a new class of regulated pharmacy practitioner could displace other pharmacy workers as well as pharmacists working behind the counter. Stakeholders feel that OCP should set guidelines on the appropriate mix of pharmacists and technicians in different service settings to ensure public safety.

HPRAC concurs with this view.

7.7 Patient Service

The OCP submits that with the regulation of pharmacy technicians, pharmacists will have more time to provide essential services to their patients and clients and other health professionals. Additional or expanded services include counselling, medication consultations, health management, and participation in prevention programs. The Lowy Inquiry recognized that these additional services are important to increasing patient safety and reducing risk of harm.

7.8 Economic Impact

The College does not anticipate any increased costs to the Government as a result of claims to the Ontario Drug Benefit Plan. The regulation of pharmacy technicians would not affect the numbers of prescriptions dispensed; that would be impacted only by changing demographics and prescriber practice patterns.

8. Summarizing the case for regulation

From a patient safety perspective, regulation of pharmacy technicians would provide standardized education and training, province-wide standardized testing, and maintenance of competency through a quality assurance program. It would also provide a transparent process for complaints, discipline, patient relations and fitness to practise programs, and increase accountability on the part of the registered pharmacy technician.

HPRAC's analysis indicates that patient safety may be jeopardized by shortages of skilled practitioners, insufficient supervision, and inconsistent administration of protocols and processes. Regulating pharmacy technicians as a class under the *Pharmacy Act, 1991* will contribute to the effectiveness and sustainability of the health system by addressing human resource issues, and better utilizing the skills of pharmacists and pharmacy technicians.

Therefore, HPRAC recommends:

> **That pharmacy technicians be a regulated profession in Ontario.**

9. Regulatory Options

9.1 Class within the College

Having concluded that the public would be better served if there were regulation of pharmacy technicians, HPRAC reviewed options as to how that could best be achieved.

The OCP proposal, supported by the CAPT, is that the regulation of pharmacy technicians should be accomplished by establishing a new class of Registered Pharmacy Technician within the College of Pharmacists.

HPRAC reviewed this proposal, along with other options, and recommends:

> **That Pharmacy Technicians be regulated as a class within the College of Pharmacists of Ontario.**

9.2 Scope of Practice and Controlled Acts

HPRAC considered whether there should be a separate scope of practice for regulated pharmacy technicians, and determined that the scope of practice, which is the general statement relating to the work of the profession, did not require change.

HPRAC then considered whether there ought to be a specific and separate clause in the *Pharmacy Act* relating to authorized acts for each profession. The alternative would be to maintain the same description of authorized acts as exists now for pharmacists for both professions. The College would then specify terms, conditions and limitations that would be applied to the registration of pharmacy technicians.

In the interests of clarity to the public, members of the profession and other health professionals, HPRAC concluded that distinct authorized acts should be defined in the Act for registered pharmacy technicians. The authorized acts for pharmacists would not change. HPRAC recommends:

That the description of Authorized Acts by pharmacy technicians should be:

> **In the course of engaging in the practice of pharmacy, a member who is registered as a pharmacy technician in accordance with the regulations is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense, sell or compound a drug.**

HPRAC further recommends that corresponding changes be made to the *DPRA*:

> **That registered pharmacy technicians be authorized to perform the dispensing and compounding of drugs, as defined in subsection 117(1) of the *Drug and Pharmacies Regulation Act*.**

9.3 Title

Regulation should allow members of the public, patients, and their families to distinguish between pharmacy technicians who are qualified for registration and those who are not qualified. HPRAC agrees with OCP's request that the title "Registered Pharmacy Technician" (R.Ph.T.) be protected for this group, and that persons who are not regulated should be restricted from using the title. This will require changes to the *Pharmacy Act, 1991* by including a reference in both the title clause and the holding out clause. HPRAC recommends:

That the restricted titles in the *Pharmacy Act, 1991* be amended as follows:

> **No person other than a member shall use the title "apothecary", "druggist", "pharmacist", "pharmaceutical chemist", "registered pharmacy technician", a variation or abbreviation or an equivalent in another language.**

and with respect to representation of qualification, that:

> **No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a pharmacist, a registered pharmacy technician or in a specialty of pharmacy.**

HPRAC advises that, in the event the College continues the certified pharmacy technician program, OCP should soon change the name of the "Certified Pharmacy Technician" title and training program, and advise its program partners and College members of this, in order to avoid confusion amongst the public, members and other health professionals. HPRAC also strongly suggests that OCP immediately consider options to enable members of the public to distinguish the credentials of all personnel who work behind the counter in a pharmacy.

9.4 Council Representation

Since registered pharmacy technicians would be a profession under the Act, it is appropriate that they be represented on the College Council. At the same time, the number of pharmacists on the Council should change. Recognizing that there are now two universities whose representatives will sit on Council, the balance between professional members and public appointees would also need to change. Therefore, HPRAC recommends:

> **That the OCP Council be composed of a) at least nine and no more than sixteen persons who are members elected in accordance with the by-laws, including at least seven and no more than twelve persons elected from among members who are pharmacists, and at least two and no more than four persons elected from among members who are registered pharmacy technicians; b) at least ten and no more than fifteen non-professional persons appointed by the Lieutenant Governor in Council, and c) the dean of each faculty of pharmacy of the universities in Ontario.**

10. Transition to Regulation

Unlike other new professions, the transitional work leading to regulation of pharmacy technicians can be completed within the College, where there is a mix of professional and public members and educators, and a tradition of involving external stakeholders in the process. This can be done through an interim committee of OCP, and there will be no additional need for a statutory Transitional Council.

10.1 Interim Committee Activity

HPRAC acknowledges OCP's initiative in laying the groundwork for a new class of regulated practitioner – the Registered Pharmacy Technician. In preparation for regulation, several actions must be completed by the interim committee of pharmacists, pharmacy technicians and educators, including, but not limited to:

Entry to Practice Criteria including
- prior learning assessments and educational requirements
- written and practical licensing examinations
- bridging programs to facilitate registration of current certified pharmacy technicians and others through additional education and training

Standards of Practice – Proficiency
- competency profile for registered pharmacy technicians
- standards of practice for registered pharmacy technicians
- educational outcome requirements based on the proposed competencies for registered pharmacy technicians

Educational Requirements
- confirmation of changes to current programs with educators and MTCU, and
- accreditation standards for educational providers

Practice Standards – Workplace
- guidelines for human resources ratios in a range of pharmacy settings
- strategy to monitor the quality of performance of registered pharmacy technicians
- guidelines regarding the working relationships between registered pharmacy technicians and non-regulated personnel.

Council
- by-laws respecting the election of registered pharmacy technicians to Council
- representation of registered pharmacy technicians on Council committees
- separate but parallel registration process for pharmacy technicians
- parallel quality assurance program for pharmacy technicians

Transparency

- code of ethics for pharmacy technicians
- communications strategy regarding the future directions for pharmacy services.

10.2 Communications

During its review of the question, HPRAC noted that many pharmacists and other professionals had less understanding of the proposal than expected, while others were relatively well informed. The response from pharmacy technicians indicates that there is broad knowledge of the matter, but it was impossible to gauge whether auxiliary personnel or members of the public had a sophisticated understanding.

HPRAC is convinced, however, that the College should undertake a broad-based strategic communications plan, targeting members of the public, related regulated health professions, hospitals, employers, pharmacists as well as pharmacy technicians and auxiliary personnel employed in hospitals or accredited pharmacies. Joint information efforts could be taken with other prescribing professions to ensure that there is knowledge and confidence about the role of registered pharmacy technicians, and the opportunity for pharmacists to undertake expanded responsibilities. Pharmacists and other interested parties should be notified of transition activities and timelines leading to the first licensing examinations.

This is a key element in the successful introduction of registered pharmacy technicians. HPRAC recommends:

> **That the College of Pharmacists of Ontario implement a strategic communications plan during the transition phase and at the entry of registered pharmacy technicians to practice.**

11. Recommendations

HPRAC recommends to the Minister:

1. That Pharmacy Technicians be regulated as a class within the College of Pharmacists of Ontario.

2. That the description of Authorized Acts by pharmacy technicians should be:

   In the course of engaging in the practice of pharmacy, a member who is registered as a pharmacy technician in accordance with the regulations is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense, sell or compound a drug.

3. That registered pharmacy technicians be authorized to perform the dispensing and compounding of drugs, as defined in subsection 117(1) of the *Drug and Pharmacies Regulation Act*.

4. That the restricted titles in the *Pharmacy Act, 1991* be amended as follows:

   No person other than a member shall use the title "apothecary", "druggist", "pharmacist", "pharmaceutical chemist", "registered pharmacy technician", a variation or abbreviation or an equivalent in another language.

   and with respect to representation of qualification, that:

   No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a pharmacist, a registered pharmacy technician or in a specialty of pharmacy.

5. That the Ontario College of Pharmacists' Council be composed of a) at least nine and no more than sixteen persons who are members elected in accordance with the by-laws, including at least seven and no more than twelve persons elected from among members who are pharmacists, and at least two and no more than four persons elected from among members who are registered pharmacy technicians; b) at least ten and no more than fifteen non-professional persons appointed by the Lieutenant Governor in Council, and c) the dean of each faculty of pharmacy of the universities in Ontario.

6. That regulations under the *Pharmacy Act* specify that receiving verbal prescriptions is not approved for registered pharmacy technicians.

7. That the Minister issue a direction specifying that protocols surrounding verbal prescriptions should specifically be addressed, individually and jointly, by the Ontario College of Pharmacists and other regulatory colleges whose members are authorized to prescribe medications: College of Physicians and Surgeons of Ontario (CPSO); Royal College of Dental Surgeons of Ontario (RCDSO); College of Nurses of Ontario (CNO); and College of Midwives of Ontario (CMO).

8. That the College of Pharmacists of Ontario implement a strategic communications plan during the transition phase and at the entry of registered pharmacy technicians to practice.

REGULATION OF HOMEOPATHY AND NATUROPATHY

The Minister's Question

In February 2005, the Minister of Health and Long-Term Care asked the Health Professions Regulatory Advisory Council (HPRAC) for its advice on:

> Whether homeopaths should be regulated under the *Regulated Health Professions Act (RHPA), 1991*, including what their scope of practice should be, what controlled acts, if any, they should be authorized to perform, and any protected titles, and whether it is appropriate that homeopaths be regulated under an existing profession specific act.[1]

HPRAC's Response

After investigation HPRAC recommends that homeopaths be regulated as a new profession under the *RHPA* in a college including members of the profession of naturopathy. HPRAC recommends that the *Drugless Practitioners Act (DPA)*, which currently governs Naturopathy, be repealed.

1. History of the Referral

Homeopaths in Ontario participated in the Health Professions Legislative Review in the 1980's, and subsequently asked for regulation under the *RHPA* in 1992. Following the Minister's request for advice from HPRAC on this matter in 2005, the Ontario Homeopathic Association (OHA) submitted its proposal for the "Regulation of Homeopathic Medicine" as a new profession under the *Regulated Health Professions Act, 1991* with a detailed scope of practice, access to a number of controlled acts and title protection.

2. Background

2.1 Homeopathy in Ontario

Homeopathic Medicine has a long history in the province of Ontario. In the 1800s, homeopathy gained full professional status and established several homeopathic medical institutions.

The College of Physicians and Surgeons of Ontario (CPSO) was formed in 1869 as a medical coalition governing body. The college council included five representatives each from both homeopathic and "eclectic" physicians. Increasingly, homeopaths received M.D. degrees from Canadian medical schools and then pursued postgraduate homeopathic studies in the United States before obtaining an Ontario license through the council's homeopathic examiners. By 1870, there were approximately fifty registered homeopaths in Ontario compared to more than 1,000 physicians.

---

[1] Minister's Referral Letter, February 2005, Appendix A

In the later part of the 1800s in the United States, homeopathic colleges were slowly becoming marginalized and eliminated by the stronger and more influential American Medical Association. No new homeopathic medical schools were established in Canada and over the course of time, the Ontario medical homeopaths themselves became marginalized. The homeopathic profession declined with the expansion of conventional medicine, the advent of antibiotics and the rise of the pharmaceutical industry. As a result, positions for homeopaths on the CPSO council were reduced from five seats to two seats and then in the late 1960s, the last homeopath on the council died and the position was eliminated.

2.2 The Current Environment in Ontario

In Ontario, the interest in complementary and alternative therapies from health care professionals and the public has increased significantly over the past decade. Thousands of Ontarians use complementary and alternative therapies as a routine part of their on-going health care. This shift in the interest in, and use of, complementary and alternative therapies can be traced to several key developments in Ontario, including evolving patterns of immigration and increasing demand from consumers who wish to take the lead in their own health care decisions, including treatment outside of traditional medicine. To this end, according to the Ontario Homeopathic Association (OHA), users of complementary and alternative therapies cross all demographic indicators, come from all walks of life and all income brackets.

A Canada-wide study sponsored by the Canadian Health Food Association, in co-operation with other similar organizations, released October 14, 2005, found that Canadians spend 2.5 billion dollars annually on natural health products.

2.3 Complementary and Alternative Therapies

Complementary and alternative therapies, including homeopathy, naturopathy, chiropractic and massage therapy are a group of diverse medical and health care systems, practices, and products that are not currently considered to be part of conventional medicine. Complementary therapies are used together in conjunction with conventional medicine. Alternative therapies are used in place of conventional medicine.

At the same time as the public is turning to these therapies, there has been an increase in the number of studies on the efficacy of complementary and alternative therapies, including systematic reviews of controlled trials, being published in peer-reviewed scientific journals.

Regulatory bodies and professional associations, as evidenced by the work of Health Canada, are responding to the increased interest in complementary and alternative therapies through the provision of education, training and guidance for their members in the appropriate use of complementary and alternative therapies.

The increase in professional and public interest in complementary and alternative therapies, combined with the on-going regulation of alternative health care providers, increased professional educational programs, the publication of systematic reviews and controlled trials is indicative of the changes in demand and the fundamental approach to alternative and complementary therapies that is underway.

2.4 Canadian Regulatory Initiatives

The rekindled interest in homeopathy in the 1980s caused the former Health Protection Branch (HPB) of Health Canada concern, as large numbers of Canadian companies were increasing their activities in the manufacture or importation of homeopathic preparations. Since these preparations are represented for the treatment of disease, they are considered drugs as defined by the Food and Drugs Act. As such, the issuance of Drug Identification Numbers (DINs) for these products to successful applicants was seen as an appropriate response from HPB, notwithstanding controversy respecting scientific proof of efficacy.

In 1990, HPB proposed the creation of special regulations related to homeopathic preparations. The proposal included accepted references for definition, labeling requirements and the creation of "HM-numbers" specific to homeopathic preparations. HM-numbers would be assigned to products that meet the HPB criteria and for which a DIN had already been issued.

At around the same time, HPB issued an Information Letter on "Traditional Herbal Medicines" providing guidance on the categorization of herbs, general labeling guidelines and standardized monographs. Although both herbal and homeopathic preparations were considered drugs "on the basis of the purpose for which the substance is manufactured, sold or represented" Health Canada made a clear distinction between "pharmaceuticals" and "Traditional Herbal Medicines."

In 1997, the federal Health Minister asked the House of Commons Standing Committee on Health to review the regulation of natural health products in Canada. This gave rise to the Office of Natural Health Products in 2000 and, after more consultation, the creation of the Natural Health Products Directorate (NHPD).

The NHPD is part of the Health Products and Food Branch of Health Canada and is the regulating authority for all natural health products for sale in Canada. The NHPD's mandate is to ensure that Canadians have ready access to natural health products that are safe, effective and of high quality. Products that fall under the NHPD's purview include all herbal remedies, homeopathic medicines, vitamins, minerals, traditional medicines, probiotics, amino acids and essential fatty acids.

In June, 2003 federal regulations were enacted respecting product licensing, site licenses, Good Manufacturing Provisions, human clinical trials and general matters. Under these regulations, all natural health products require a product license before they can be sold in Canada. Obtaining a license requires that detailed information on the product be submitted to

Health Canada for review. Once a product has been assessed and granted market authorization by Health Canada, the product label will be granted a license number preceded by the distinct letters NPN, or, in the case of a homeopathic medicine, by the letters DIN-HM. This number on the label is designed to inform consumers that the product has been reviewed and approved by Health Canada for safety and efficacy.

As of February 2006, the NHPD is considering the creation of a separate schedule for natural health products that are considered to be of higher risk.

At the provincial level, in the fall of 2005 Ontario introduced Bill 50, the *Traditional Chinese Medicine Act* to regulate the practice of Traditional Chinese medicine under the *RHPA*. Under the Act, Chinese medicine is considered a holistic system of health care that includes acupuncture, herbal therapy, tuina massage, and therapeutic exercise. With the passage of the *Traditional Chinese Medicine Act*, Ontario will be the second province in Canada, after British Columbia, to regulate traditional Chinese medicine.

2.5 Public Demand

Consumers have indicated that they want choice, including access to alternative and complementary medicines.[2] HPRAC's own market survey, while not statistically significant, indicated that between 10 per cent and 20 per cent of consumers looking for alternative remedies are seeking homeopathic remedies. Most are doing so without direction from a pharmacist, homeopath or other health care practitioner. Many seek advice from staff at retail stores or pharmacies.

According to a 1999 national survey by the Berger Population Health Monitor, more than 25 per cent of Canadians reported using some form of alternative health care,[3] up from 20 per cent in March 1993. With regard to naturopathy, in March 1999, three per cent of Canadians 15 and older reported using a naturopath at least once in the previous six months. This compares to one per cent in March 1993.[4]

In a 2002 report, Agri-Food Canada observed that the self-care products industry generated approximately $2.9 billion in sales per year. Growth has been driven, in part, by the increased availability of natural self-care products and products including herbal and homeopathic products. The Nonprescription Drug Manufacturers Association of Canada (NDMAC) estimates the total 2005 sales for the self-care health products industry at $3.8 billon. This represents a 30 per cent increase in three years.[5]

Other studies indicate that many Canadians living with chronic conditions supplement conventional care with the use of alternative therapies. One study found that 39.4 per cent of women who were recovering from breast cancer reported visiting a complementary and alternative practitioner –

---

[2] ICES website: www.ices.on.ca/docs/fb2290.htm

[3] *The Berger Population Health Monitor, Survey No. 19*, March 1999.

[4] *The Berger Population Health Monitor, Survey No. 19*, March 1999.

[5] *Strategic Market Management System: Pharmaceuticals*, Agriculture and Agri-Food Canada. June, 2002

most commonly chiropractors, herbalists, acupuncturists, traditional Chinese medicine practitioners or naturopathic practitioners.[6]

Consumers have choice in the selection of remedies and health care providers. HPRAC believes that they should also have the confidence that those who provide their care are adequately trained, operate within an appropriate scope of practice, provide safe care and are accountable for the services they provide.

3. HPRAC's Approach to the Question

3.1 The Consultation Process

The Ontario Homeopathic Association (OHA) submitted its proposal for the "Regulation of Homeopathic Medicine" to HPRAC soon after the Minister's referral. The Advisory Council posted the OHA submission on its website and invited comments. Some 97 responses were received and analyzed. Submissions were received from homeopathic practitioners, homeopathic schools and associations, other associations and members of the public.[7] Key informant interviews, a stakeholder workshop and numerous meetings were held to clarify information and opinion and to gather new material. The consultation process helped identify where views differed between stakeholder groups, and where there was commonality. A retail marketing and manufacturing review supplemented the consultation process, along with an extensive literature and jurisdictional review.

4. What is Homeopathy?

Homeopathy is a system of medicine which seeks to treat disease in accordance with so-called natural laws of healing. Developed by Samuel Hahnemann in the 1800s in Germany, the practice uses infinitesimal amounts of plant, animal and mineral substances which, in a healthy person, cause the symptoms of the disease being treated. The principle that a disease with a given set of symptoms can be cured by a medicine which is known to produce a similar set of symptoms is called "The Law of Similars." It is the foundation of homeopathic medicine.

> *The Similum or Law of Similars:* This basic law of homeopathy is *similia similibus curentur:* 'let likes be cured with like'. Based on this premise, the first homeopathic principle states that any substance that can make you ill can also cure you - anything that is capable of producing symptoms of disease in a healthy person can cure those symptoms in a sick person. By 'symptom' the homeopath means those changes that are felt by the patient (subjective) or observed (objective), which may be associated with a particular disease, or state of disease, and which are the outward expression of that state.[8]

---

[6] Boon et. El., 2000

[7] Submissions are posted on the HPRAC website, *www.hprac.org*

[8] Miranda Castro R.S. Hom., *The Complete Homeopathic Handbook*, 1990

According to the OHA, it is the role of homeopaths to restore, improve, promote and maintain physical and emotional well-being and to assist in preventing, restoring or palliating disease by assessing the patient's overall condition. The homeopath prescribes homeopathic remedies and provides supportive courses of action including holistic nutrition and natural health care treatments to treat, remove, correct, or palliate disease conditions.

The core practice of homeopaths is the prescribing of homeopathic remedies. Other modalities such as dietary changes, vitamins, minerals and nutritional supplementation may be utilized as adjunctive and complementary methods in order to support and maintain the integrity of the homeopathic course of treatment. However, homeopathy *per se* is a specific treatment system compared with the general, primary care of naturopathy which features integrated therapies.

HPRAC heard that homeopathic remedies are derived from plants, minerals, metals, acids, alkalis, animal venoms and diseased human tissue. Homeopathic remedies are created through a multi-step process of serial dilution and succussion (shaking) or trituration (grinding), by which the inner medicinal power of a crude substance (the mother tincture) is released or increased – the higher the dilution, the more powerful the remedy, according to homeopathic theory. HPRAC was told that the dilutions make it possible to use poisonous substances safely.

Clinical trials to establish efficacy of remedies are rarely used in homeopathy. Instead, a process called "proving", which is a single trial with a single individual, purports to establish the medicinal effect of the substances used in homeopathic practice. Remedies rely on cumulative findings from "provings" that have been collated since Hahnemann's time. These are found in the homeopathic *materia medica* which is used by practitioners to recommend remedies for symptomatic clients. The volume of homeopathic remedies (currently more than 2,000) led to the creation of repertories. A repertory is a dictionary of symptoms in alphabetical order, where each symptom is followed by the remedies known to cause that symptom in the provings. Remedies are graded as to their efficacy. Based on a patient's symptoms, the homeopath prepares or recommends a suitable dilution of a homeopathic medicine. This process is called "potentization".

HPRAC notes that homeopathic principles are not accepted by all. A significant number of conventional medical practitioners, allied professions and clinical scientists seriously question the efficacy of homeopathy and regard it as unsafe. They point to the fact that there is no body of evidence that shows that homeopathic principles when translated into practice are efficacious.

5. What is a homeopath?

A trained homeopath believes that human beings naturally function in a state of harmony between mind, body and spirit. This is called homeostasis. According to homeopaths, when injured, the organism will act to repair the damage. Attendant symptoms are indicative, not of ill-health, but of a process of self-correction or healing. Symptoms therefore guide homeopathic remedy choices, demonstrate how the healing process is proceeding, and guide ongoing treatment and assessment.[9] Homeopaths assert that nothing can be known about disease except what is seen in the symptoms, and that nothing can be cured except the symptoms. That said, a well-trained homeopath should be familiar enough with medical sciences to:

- understand disease to identify the need for appropriate treatment – homeopathic, naturopathic or allopathic/conventional medicine
- differentiate between common symptoms of a disease and those unique to the individual.
- understand the function and impact of medications to ascertain what symptoms are drug-related.[10]

Homeopaths are not currently regulated in Ontario. Anyone may call him or herself a homeopath and offer homeopathic services and remedies regardless of their education, training and qualifications.

Ontario has approximately 500 homeopaths on the rosters of various homeopathic associations and organizations. Of these providers, approximately 200 work in practice either as solo-practitioners or with other homeopaths. The other providers work in a variety of settings such as unregulated environments, and in private practice with other regulated health professionals. Some are said to practise on a part-time basis.

5.1 Education and Training

Seventeen homeopathic teaching institutions currently operate in Canada. Nine private career colleges that provide education and training in homeopathy operate in Ontario. Each school has different training standards, offers different programs and awards different diplomas or certificates. In one case, courses are taught by distance education with students required to complete a preceptorship with a qualified homeopath. Courses vary in length and content from short correspondence courses to 4-year certificate programs, with total course hours ranging from 728 to 3,045. Admission requirements vary for each school or program.

The OHA estimates that 75 per cent of homeopaths practicing in Ontario were educated in the province, while the rest were trained elsewhere in Canada, the United States, India or other countries.[11]

5.2 Accreditation of Homeopathic Educational Institutions

There is no legitimate accreditation agency or program for homeopathic education programs in Ontario or Canada. In addition, the accreditation standards of the bodies that represent themselves as accreditation authorities are virtually inaccessible to the public or practitioners.

---

[9] OHA, Application…for the Regulation of Homeopathic Medicine, April 2005, pg 4

[10] Ibid, pg 6

[11] OHA, Application…for the Regulation of Homeopathic Medicine, April 2005, pg 47, 48

The Ontario College of Homeopathic Medicine (OCHM), claims to be accredited by the Ontario Homeopathic Association. However, the OHA is a professional association, not an accrediting agency. The Homeopathic College of Canada (HCC) claims to be accredited by the Homeopathic Medical Council of Canada (HMCC). The National United Professional Association of Trained Homeopaths (Canada) (NUPATH) claims to be an accrediting body and accredits the Hahnemann College of Heilkunst, the British Institute of Homeopathy, Canada and the Toronto School of Homeopathic Medicine.

The Council on Homeopathic Education (CHE), a private, not-for-profit, U.S. agency is the closest to an accreditation body, as assessing homeopathic training in the U.S. and Canada is its main purpose. Established in 1982 in Virginia, the CHE is an independent agency, which accredits training in Canada and the U.S. It consists of representatives from founding homeopathic community organizations, all accredited schools and three at-large members of the homeopathic public.The Toronto School of Homeopathic Medicine claims to be the only school in Canada to be accredited by the CHE.

While these organizations and associations claim to accredit schools and programs, none of these bodies is formally recognized as an accrediting agency. A review of the database of "Accrediting Agencies and State Approved Agencies" recognized by the U.S. Secretary of Education does not list the CHE as a recognized accrediting agency.

5.3 Who uses homeopathic therapies?

Users come from all walks of life. They range from people who believe in natural health remedies to those who have exhausted conventional medical options in the treatment of chronic stress, pain or other conditions. Consumers often choose homeopathic remedies as an aid to changing lifestyle, or as an alternative to antibiotics or other conventional medications that they believe are no longer effective.[12]

Children are most often treated for ear, nose and throat conditions, and behavioural problems such as hyperactivity. Parents may turn to homeopathy to avoid prolonged use of conventional drugs over long time periods. People dealing with chronic or terminal conditions may resort to homeopathy for relief from drug-induced symptoms such as nausea, vomiting, depression and hopelessness.[13]

A Fraser Institute study published in 1999 indicated that eight percent of Canadians have used homeopathy (six percent of Ontarians) and that 17 percent of Canadians have used herbal remedies (19 percent of Ontarians). In Quebec, five private insurance companies (representing 25 per cent of the total number of companies then in the market) provided coverage for homeopathic services in the late 1980s. The number of claims presented grew from close to 1,500 in 1988 to 4,500 in 1989.

---

[12] Ibid, pg 9

[13] Ibid, pg 10

5.4 How the public receives services

Homeopathic services are not an insured service under the Ontario Health Insurance Plan (OHIP). It is believed there are no homeopaths working in institutional or community settings in Ontario; rather, homeopaths work in private practice, sometimes in conjunction with regulated or unregulated health care providers.

During an initial consultation, a homeopath will spend from one-and-a-half to two hours on "case taking." The client describes his or her symptoms without interruption from the practitioner. However, "promptings" may be used to encourage disclosure.

> In this way, the client identifies the problems…within his or her own frame of reference. This is extremely valuable information… as prescribing a remedy is based on the unique symptoms as opposed to the common symptoms of illness...The mental state of a patient is [also] of critical importance for a homeopathic assessment.[14]

Once the case-taking process is complete, the homeopath will augment the client's profile by obtaining medical, personal and family histories. Practitioners engage patients by identifying physical symptoms to be treated and monitoring progress.

6. The Ontario Homeopathic Association (OHA)

The OHA was formed as a not-for profit voluntary association in 1992 with the goals of gaining recognition for homeopathy as a profession in Ontario's health care system[15] and to promote safe and effective health care to the public by qualified homeopaths. In this regard, the OHA has set minimum standards of practice for its members. Membership in the OHA is voluntary; it is said to represent about 40 per cent of the estimated 500 practitioners in Ontario. Members of the OHA must meet the education and practice requirements set out by the association, and adhere to a code of ethics. The OHA has itself accredited two schools, the Ontario College of Homeopathic Medicine and the Manitoba College of Homeopathic Medicine, in which a prerequisite for admission is three years of university education. The OHA also reports that it is in the process of establishing qualifying (or Board) examinations.[16]

7. The OHA Proposal

In April, 2005 the OHA submitted its proposal to HPRAC for the regulation of homeopathy in Ontario under the *Regulated Health Professions Act, 1991*.

---

[14] Ibid, pg 5
[15] Ibid, pg 11
[16] Ibid, pg 43

The OHA application to HPRAC makes the following requests:

1. That the detailed scope of practice for Homeopathy be as follows:

    > Homeopathic Medicine is a system of medicine that promotes, restores and maintains health, treats disease, prevents future illness and improves well being, vitality and good health through the assessment, diagnosis and treatment of acute and chronic illness, the prevention of illness, and the education in the maintenance of good health using natural substances in accordance with Homeopathic principles.

2. That the titles "Homeopathic Doctor"; "doctor of Homeopathy" and/or "Homeopath" be protected.

3. That homeopaths be granted access to the following five Controlled Acts under the *RHPA*:

    - Communicating a diagnosis
    - Performing a procedure on tissue below the dermis
    - Administering a substance via injection or inhalation
    - Applying or ordering the application of a form of energy prescribed by the regulations under this Act;
    - Prescribing, selling and compounding drugs.

4. That the prescription of Homeopathic remedies of a 200 CH potency and up (and its equivalent in other scales) and certain low dilutions as stated in the Homeopathic Pharmacopoeia of the U.S. (HPUS), be the exclusive jurisdiction of Homeopathic Doctors and other health care professionals properly trained in Homeopathy.

5. That remedies made from narcotics, biological poisons, venoms and diseased human tissue be granted as the exclusive domain of Homeopathic Doctors and other health care professionals properly trained in homeopathy.

The OHA application submits that there are several key factors underlying their requests, most notably:

- That homeopathy is a system of medicine, just as conventional medicine and Traditional Chinese Medicine are systems of medicine;
- That there is a serious, albeit indirect risk of harm, presented to the public by homeopathy, especially by those who are not adequately or appropriately trained to act as homeopaths;
- That homeopaths undertake extensive education and training regarding the nature and usage of the thousands of homeopathic substances including extensive, comprehensive, in-depth university

level training and knowledge of anatomy, physiology, pathology, biochemistry, physical examination, differential diagnosis and related medical courses, as well as copious hours of clinical internship;

- That there is an increasing use of and reliance on alternative therapies such as Homeopathy; and
- That the unique, specialized and holistic approach to health and preventative health care that homeopathy provides should be recognized.

8. Responses to the OHA Application

In June, 2005, the OHA application was posted on the HPRAC website, and comments invited. There were 97 submissions received in response to the OHA application from educational institutions, associations, regulatory bodies and individuals.

Key issues raised by the respondents included:

- Further examination of both the practice of homeopathy and the appropriate regulatory scheme for the profession is required.
- Questions about whether the practice of homeopathy meets the threshold risk of harm to the public criterion.
- Concerns about OHA's proposals regarding:
    - Scope of practice
    - Educational requirements
    - Request for access to five Controlled Acts.
- Concerns that the OHA had not consulted broadly within the homeopathic community in the preparation of its submission, and the submission represented a point of view of only one sector of homeopathic practitioners.
- Broad agreement that the status quo is no longer an option for homeopathy.

The concerns expressed regarding the OHA application revealed a distinct attitudinal difference to homeopathic practice with one group of respondents holding that practitioners should not be engaged in a "disease diagnosis" approach, instead focusing on a homeopathic practice that involves symptomatic treatment using "safe and gentle" modalities. There was also a strong inference that additional consultations could bring the various factions in homeopathy together to work towards a regulatory framework which practitioners would recognize as valid.

Following the receipt of responses to the submission on the regulation of homeopathy by the OHA, HPRAC conducted interviews with key informants in homeopathy, including homeopathic practitioners representing four associations; practitioners representing four schools, one individual practitioner and two practitioners of naturopathy. These interviews produced agreement that, given the indirect risk of harm and the increasing need for public accountability, the status quo is not an acceptable option for the practice of homeopathy. Codified entry requirements, common practice standards and codes of conduct for homeopaths are generally supported. There is also general agreement that indirect harm, such as misapplying homeopathic principles due to lack of training, misdiagnosis or fraud, presents serious risks to the public. Most would like to see education and training qualifications for homeopaths raised.

Four major issues relating to the practice and regulation of homeopathy emerged with respect to the OHA submission:

1. Risk of Harm

Many respondents did not believe that the case for risk of harm was a result of direct harm arising from treatment with homeopathic remedies. Some suggested that homeopathy, like any other medical system, has the potential to cause harm, and the likeliest cause of harm is indirect, for example an incorrect assessment, failure to refer or fraud.

2. Controlled Acts

The OHA submission seeks to grant homeopathic practitioners access to five controlled acts under the *RHPA*. It was widely argued by the key informants that none of the controlled acts requested by the OHA are mandatory for the practice of homeopathy.

3. Training

Many respondents indicated that the training qualifications identified by the OHA are representative of a single school of thought within homeopathy. The informants felt that the approach taken by the OHA is biased toward conventional medicine with inadequate coverage of homeopathic practice. Participants would like to see the education and training qualifications for homeopaths broadened to reflect the larger body of knowledge that comprises homeopathy.

4. Regulation

There is broad agreement that the status quo is not acceptable. Respondents see merit in codified entry requirements, common practice standards and codes of conduct for homeopaths. Conferring and protecting the "Homeopathic Doctor" title is generally supported.

Subsequent consultations showed increasing agreement that some form of regulation of homeopathy is required, especially given the indirect risk of harm associated with the practice. While it was acknowledged that homeopathic remedies are generally safe and evidence of direct harm is largely anecdotal, it was also agreed that improper dilutions of "mother tinctures" of homeopathic remedies by unqualified practitioners have the potential for serious harm. Further, it was pointed out that regulatory agencies such as the United States Federal Drug Administration and Health Canada imply that supervision of trained professionals is needed for safe administration of homeopathic treatments.

Further discussions with the OHA indicated that it is possible for its members to function without the controlled act of communicating a diagnosis. Access to the other acts, such as administering a substance by injection or inhalation is not as applicable to current homeopathic practice standards today, according to the OHA, but may be required as the profession and therapies develop. The OHA continues to believe the *RHPA* is the most appropriate vehicle for the regulation of homeopathy.

9. HPRAC's Literature, Jurisdictional and Market Reviews

9.1 Literature Review

The material on the subject of homeopathy is voluminous; thousands of books and publications and close to two million Internet sites exist, many of which explain the practice, promote homeopathic remedies, give treatment advice or describe career opportunities. Internet technology has leveled the business playing field, including the "business" of healthcare, and individuals looking for alternatives to orthodox medicine encounter challenges in identifying the expertise and independence of information on the web. Outside opinions range from outright rejection of homeopathy as an unscientific fad by the U.S. National Council Against Health Fraud to an embracing of the practice, along with other alternative modalities, by the Prince of Wales's Foundation for Integrated Health in the U.K.

HPRAC divided its review of the literature into sections: Self-Treatment, Canadian Research, Alternative Medicine Self-Regulation in Ontario, a Definitive Reference Book, The "Market", The Problem of Harm, and utilized the materials in its review and analysis of the question. HPRAC found that publications explaining homeopathy and recommending medicines for self-treatment may be challenging for the lay reader, since many rely on the complex theories of homeopathy and a language unique to homeopathy as a base for documentation.

9.2 Jurisdictional Review – Homeopathy

HPRAC's review of jurisdictions summarized approaches to regulating homeopathy in Australia, South Africa, Great Britain, New Zealand, India, the European Union, and the United States.

Approximately 81 countries demonstrate some degree of regulatory involvement in homeopathic practice with a wide range of education and training, statutory regulation and voluntary self-regulation evident. Forty-eight countries belong to an international society known as LMHI (Liga Medicorum Homoepathica Internationalis) that seeks consistency in homeopathic regulation. Canada is not a member of this organization.

The few countries that formally regulate homeopathy are, in general, developing countries with the exception of South Africa. Approximately 24, largely developing countries, have laws which sanction homeopathic practice by medical doctors, with specialty education and training established.

A voluntary system of registration in Australia features a strong professional cohesiveness among various professional homeopathic societies. While the UK currently has a voluntary system, it is moving towards a statutory approach, and the European Union is also considering more formal regulation.

Experiences in the United States and the United Kingdom have been particularly informative.

United States[17]

A variety of regulatory models have been instituted in different states. There are those who see complementary and alternative medicine (CAM) as a basic right of consumer choice and others that would restrict its practice by imposing registration and standards.

"Basic rights" proponents have advanced consumer "Health Freedom" Acts in California, Minnesota, and Texas as well as a number of other states. In these jurisdictions, there is no formal registration or licensing, voluntary self-regulation is acceptable, there are no restricted acts, and choice is in the hands of the consumer.

Restrictive states include Georgia, New York, and North Carolina. These states impose legal sanctions on diagnosis and treatment and restrict scopes of practice. Where permitted the use of CAMs is frequently restricted to physicians.

Dual registration is permitted in Arizona[18], Connecticut and Nevada. All have regulations licensing medical doctors to practice homeopathy.[19] Should one license lapse, a dually licensed practitioner may continue to practice under the terms of the other license.

United Kingdom

Britain is moving from a common law approach relying on voluntary standards and compliance with enforcement through the courts, toward statutory regulation.[20] This progression follows successive efforts to develop and apply standards outside of a legislative framework.

---

[17] Ibid, pg 26. The *Homeopathic Pharmacopoeia of the United States* is a recognized reference by the FDA, which does not require manufacturers to comply with Drug Food Manufacturing Practice rules. The FDA asserts that there are no "real safety concerns" with homeopathic products.

[18] Problems have arisen in Arizona where the Board of Homeopathic Medical Examiners has been faulted for admitting members under investigation or barred from practice in other states. Legislators have called for an audit. The Board has not been audited for 20 years and is scheduled for a sunset review in 2006; (Arizona Republic, November 9, 2005 [www.azcentral.com])

[19] National Center for Complementary and Alternative Medicine –NCAM- Point 3.

[20] Common law is law developed from custom and court decisions. Statutory law is imposed by legislation.

In 1997, "National Occupational Standards" elaborating standards of practice were developed by associations representing homeopaths and academics from homeopathic teaching institutions.

Three years later, the Council of Organizations Registering Homeopaths was established as a transitional body pending the establishment of a nation-wide register – the New Registering and Regulatory Body. Objectives of the NRRB include developing further codes regarding ethics, professional conduct, course accreditation and quality assurance, and registration.

That same year, the House of Lords Select Committee on Science and Technology issued a report calling for better regulation of homeopathy along with other complementary and alternative medicines including chiropractic, osteopathy, acupuncture and herbal medicine. On homeopathy in particular, the Select Committee commented that "statutory regulation may ultimately be appropriate."

The drive for regulation is being spearheaded by the Prince of Wales' Foundation for Integrated Health. The Foundation supports the integration of complementary and conventional medicine in Britain, and is working on a statutory model for the regulation of homeopathy.

9.3 Retail / Marketing / Manufacturing Review

Given the nature of homeopathic remedies and their availability as over the counter products in many pharmacies, natural food stores and other retailers, a series of meetings and store visits with a sample of retailers of homeopathic products were undertaken by HPRAC in order to obtain a sense of the market for homeopathic remedies, current demand for these products and services, and some insight into the consumers who use them. This market review was limited in scope and did not yield statistically significant data. It was, however, useful in that it confirmed an increasing public interest in homeopathic remedies.

The review included the following retailers and manufacturers:

- Non-pharmacy outlets
    - seven health food/nutritional outlets that also advertise homeopathic remedies;

- Pharmacy outlets
    - five pharmacies that specialize in alternative/interpretive medicine, including homeopathy;

- Manufacturers dedicated to supplying homeopathic remedies to the market;

- Key associations
    - Canadian Association of Chain Drug Stores
    - the Ontario Pharmacists' Association
    - the Canadian Association for Pharmacy Distribution Management
    - the Canadian Health Food Association

- the Non-Prescription Drug Manufacturers Association of Canada
- "Nu-life" distributors.

Based on information provided in meetings and store visits, it appears to HPRAC that about 10 to 20% of consumers who routinely use these retailers are seeking homeopathic remedies. Within this cohort of consumers, there remains considerable confusion regarding the differences between naturopaths and homeopaths and a general inability to distinguish naturopathy from homeopathy. Of consumers seeking homeopathic remedies, a majority is reportedly seeking a specific product; however most consumers do not have written directions from a homeopath or other health care practitioner. Significant numbers of customers indicated that they look for homeopathic remedies as a result of "word of mouth" recommendations or frustration at lack of successful outcomes with conventional medicines. Consumers that purchase homeopathic remedies commonly also buy other products such as supplements, natural foods products or vitamins.

Some retail outlets have access to a homeopath, either on staff or available on-call. All the pharmacists contacted by HPRAC who retail alternative medicine products have had some training in homeopathy.

When consumers seek advice from pharmacy staff, which is common, they usually seek information in a limited number of well defined areas:

- Colds/influenza/allergies (Oscillococinum)
- Bumps and bruises (arnica)
- Teething/colic in infants
- Migraine
- Arthritis
- Post menopausal problems

According to the Canadian Association of Chain Drug Stores, homeopathic remedies may not have themselves experienced dramatic growth, although other complementary products such as nutritional supplements, herbals, vitamins are seeing strong market growth. Retailers agree that the use of these remedies for self treatment of self-limiting ailments is generally safe and that the products available for 'over the counter' sale were adequately regulated by Health Canada. Products deemed to be more potent through serial dilutions are subject to restricted access and provided after consultation with a homeopathic practitioner. Retailers generally favour some form of regulation for homeopathy, especially to control those who inappropriately represent themselves as homeopaths, whether or not they have training in the field. To this end, regulation of the practice of homeopathy was seen as desirable.

10. HPRAC's Consideration of the Proposal

Despite the divergence in views among homeopathic practitioners, HPRAC decided to proceed with its consideration of the OHA proposal, taking into account other significant submissions, for several reasons. Chief among these is agreement within the homeopathic community that the status quo is not an option, and that some form of regulation is desirable.

HPRAC is also of the opinion that the increasing popularity of complementary and alternative medicines (CAMs), of which homeopathy is a part, means that the proposal should be considered at this time.

Finally, HPRAC accepts that lines between disciplines have blurred with naturopaths bringing homeopathic methods into their practices. Both disciplines are also incorporating herbal pharmacology into their practices.

11. Factors Informing HPRAC's Recommendations

11.1 Risk of Harm

Many people use complementary and alternative medicines because they believe that treatments are natural and without side-effects. HPRAC's literature review indicates that this is not always the case. There is the risk of both direct and indirect harm. In the absence of regulation, consumers face heightened risks associated with:

1. **The homeopathic approach** – specifically preventing other effective (medical) interventions[21], or discouraging immunization.[22]
2. **Practitioners** – misapplying treatments, improperly compounding remedies or overstepping their qualifications,[23] or failing to refer to conventional care while waiting for results from homeopathy.[24]
3. **Products** – or remedies which are contaminated or improperly compounded.

The OHA, along with other practitioners, acknowledges the under-reporting of adverse effects.[25]

> ***Direct Risk*** – Examples of direct harm are: adverse reactions; allergic reactions to low potency homeopathic preparations; and misapplication. Direct harm can also result from compounding where treatments with potentially toxic concentrations of arsenic and cadmium are dispensed.[26] Examples cited in the literature are arnica causing fatal haemorrhaging in individuals taking blood thinning agents, caulophyllum producing abortion[27], diaper rash remedies causing mercury poisoning[28], and arsenic toxicity.[29] A German pharmacologist (W. Loscher) writing

---

[21] Thompson, S. (1999). Homeopathy: A critique. Presented to the full council of the Medicines Control Council, Pretoria, 23 July 1999.

[22] Ernst, E. (2005). Is homeopathy a clinically valuable approach? *Trends in Pharmacological Sciences*, Article in Press.

[23] Reilly, D. (2003). The evidence for homeopathy. Paper produced for a Harvard Medical School course.

[24] Canadian Paediatric Society (2005). Homeopathy in the paediatric population. *Paediatrics & Child Health*, 10 (3), pg 173-177.

[25] OHA, Application…for the Regulation of Homeopathic Medicine, April 2005, pg 21.

[26] Crellin, J. & Ania, F. (2002). Professionalism and Ethics in Complementary & Alternative Medicine, pg 79-80.

[27] Thompson, S. (1999). Homeopathy: A critique. Presented to the full council of the Medicines Control Council, Pretoria, 23 July 1999.

[28] Montoya-Cabrera MA, Rubio-Rodriguez S, Velazquez-Gonzalez E, Avila Montoya S. (1991). Mercury poisoning caused by a homeopathic drug. *Gac Med Mex*. 127(3). 267-79

[29] Chakraborti D, Mukherjee SC, Saha KC, Chowdhury UK, Rahman MM, Sengupta MK (2003). Arsenic toxicity from homeopathic treatment. *J Toxicol Clin Toxicol*. 41(7). 963-7

> about the attractions and dangers of homeopathic therapy observes that, in the case of toxic compounds – especially those with carcinogenic or allergic potential, homeopathy bears significant risks for humans.[30]
>
> ***Indirect Risks*** – include: misdiagnoses; missed diagnoses; disregarding contra-indications; discontinuation, prevention or delay of effective therapy; potentially hazardous diagnostic procedures;[31] and interference of remedies with conventional treatments.[32]

Harm in the form of prolonged suffering may result from homeopathic "aggravations" or "healing crises" where symptoms become worse before improving.[33] This can cause extreme discomfort for sufferers of chronic disease such as gall bladder disease or gingivitis.[34] An audit carried out in the Bristol Homeopathic Hospital Outpatient Department over a two-month period in 2005 found that reactions were frequent. Twenty-four per cent of patients experienced an aggravation. Eleven per cent reported an adverse event. Twenty-seven per cent of patients described new symptoms while 18 per cent reported a return of old symptoms.[35] Auditors concluded that remedy reactions are common in clinical practice and that recording side effects would facilitate broader understanding and enable standards to be set for information audits and patient care.

Other studies of adverse side effects from homeopathic remedies place the incidence rate between five per cent and 40 per cent.[36]

Respondents to the OHA proposal generally felt that the risk of indirect harm from misdiagnosis, failure to refer and fraud were the greatest risks to consumers. There was less agreement as to whether there is direct harm arising from the use of homeopathic remedies. Many respondents felt that homeopathic remedies are safe and pose little or no risk.

11.2 Conflict of Interest

The question of conflict of interest arises when a practitioner who has the discretion to prescribe or recommend a treatment also dispenses the medication to the patient. Regulated health colleges have standards of practice and regulations regarding conflicts of interest.

---

[30] Loscher, W., *[Homeopathy: an effective and risk-free alternative to conventional pharmacotherapy? Part 1: Hahnemann and his teaching]*. Dtsch Tierarztl Wochenschr, 99 (2), 51-4.

[31] Ernst, E. (2002). Assessing the evidence based for CAM, in Merrijoy, K.., Wellman B., Pescosolido, B. & Saks, M. (Eds). *Complementary and Alternative Medicine, Canada*: Harwood Academic Publishers, pg 165-173.

[32] Ernst, E. (2001). Intangible risks of complementary and alternative medicine. *Journal of Clinical Oncology*, 19 (8), pg 2365-2366.

[33] Ernst, E. (2005). Is homeopathy a clinically valuable approach? *Trends in Pharmacological Sciences*, Article in Press.

[34] Thompson, S. (1999). Homeopathy: A critique. Presented to the full council of the Medicines Control Council, Pretoria, 23 July 1999.

[35] Thompson, E., Barron, S., Spence, D. (2004). A preliminary audit investigating remedy reactions including adverse events in routine homeopathic practice. *Homeopathy*, 93(4), 203-9.

[36] Dantas, F. & Fisher, P. (1998). *A systematic review of homeopathic pathogenetic trails ('provings') from 1945 to 1995*, published in the United Kingdom. Thompson, S. (1999). Launso, L. & Rieper, J. (2005). General practitioners and classical homeopaths treatment models for asthma and allergy. *Homeopathy*, 94, pg 17-25.

For homeopathic practitioners, potential conflicts of interest arise when the homeopathic remedy or product is inextricably bound to the condition they are treating.

11.3 Body of Knowledge and Qualifications

Among practitioners, there is general agreement with the description of homeopathic principles as set out in the OHA proposal. There is also consensus that knowledge of the *materia medica* is a core body of knowledge unique to the practice of homeopathy

> ***Body of Knowledge*** – The homeopathic body of knowledge encompasses several pharmacopeias (such as the Homeopathic Pharmacopoeia of the United States of America, the Homeopathic Pharmacopoeia of the United Kingdom, the Homeopathic Pharmacopoeia of India, and more from France and Germany), and other scholarly works covering: Organon of the Medical Art, 6th edition; Materia Medica (various); Repertories (various); Case Taking; Hierarchization of Symptoms; Repertorization; Diagnosis; Homeopathic Differential diagnosis; and Homeopathic literature in Journals, Periodicals and Scientific Literature.[37] For some homeopaths, the body of knowledge also consists of anatomy, physiology and pathology, holistic nutrition, holistic botanical medicine, holistic environmental medicine, holistic community health, and holistic lifestyle counselling.
>
> ***Entry to Practise Exam*** – There is no standardized qualifying exam. This is a particular concern in light of the numerous (17) bodies offering training in Canada and elsewhere. Each has its own curricula with varying hours of study and practicum requirements.

Some respondents to the OHA proposal indicated that they would like to see education and training qualifications broadened, so as to be less biased towards conventional medicine.

11.4 Accrediting Bodies

A related issue concerns the credentials of the training bodies accrediting homeopaths. Writers commenting on experience in the United States drew attention to the presence of "Diploma Peddlers" and "diploma mills" especially in Maryland, Florida and Arizona. These so-called "graduates" represent a threat to public safety and undermine the credibility of legitimate practitioners. Legislators are responding by examining state regulation.[38]

This report has previously noted the deficiency of, and competing claims regarding, accreditation of educational institutions.

---

[37] OHA, Application…for the Regulation of Homeopathic Medicine, April 2005, pg 37

[38] Julian Winston, *The faces of homeopathy*, 1999, Great Auk Publishing, N.Z.

11.5 Sufficiency of Supervision

Of the 500 practitioners working in Ontario, the OHA estimates that 40 per cent are in private practice either alone or with unregulated colleagues, while 60 per cent work in a variety of settings such as unregulated environments, and in private practice with regulated health professionals. Homeopaths are independent practitioners who are not supervised. There are some examples of interdisciplinary collaboration between pharmacists and homeopaths, but these situations are essentially a matter of co-existence with no performance monitoring.

Homeopaths also frequently work in unregulated environments such as health food stores and are not publicly or professionally accountable to a publicly regulated supervisor, a publicly regulated institution or a regulated profession who may assign homeopathic services.

There are a number of voluntary professional associations for homeopaths; however, the standards for membership in the associations differ and none of these groups is able to effectively monitor the quality of their members' performance.

11.6 Public Accountability

Clients often turn to homeopaths after becoming disaffected with conventional health care providers and treatments. This, coupled with the reportedly intense nature of the relationship between the patient and the homeopath, can introduce the risk of sexual abuse. Without enforceable practice standards and accountability mechanisms, clients are without recourse except through pursuing civil or criminal action before the courts at great personal cost.

HPRAC does not observe a proactive approach to professional accountability, although respondents frequently agree that greater emphasis should be placed on the public interest, including a complaints, investigation and discipline process; greater professional and regulatory transparency; clear standards of practice; and professional guidelines and ethics. The OHA has made attempts at public accountability via the development of a complaints and discipline process, a code of ethics, definitions of professional misconduct and incompetence, and standards of practice (as demonstrated in their submission to HPRAC); however, they only represent 40% of the homeopathic practitioners in the province and they lack enforcement capacity.

If the profession were regulated, the college would be responsible for developing and maintaining high minimum standards for education and qualifications, general practice standards, on-going professional development and a formal complaints, investigations and discipline process, all of which would address the current lack of formal accountability for homeopaths.

The *RHPA* includes mechanisms to improve quality of care, including quality assurance and patient relations programs and emphasizes increased accountability and openness in the governance of each profession.

11.7 Communicating a Diagnosis

Classical or lay-homeopaths practice without medical or naturopathic qualifications and deny that they perform or communicate a diagnosis. It is likely that the consumer is unaware of this distinction, especially after having participated in an extensive interview and examination. Consumers may take false comfort in the apparent scientific basis of this process. It could leave them vulnerable to mishaps from the homeopath's inability, for example, to properly assess contraindications between homeopathic remedies and conventional medications due to a lack of training. This could occur even where lay-homeopaths require a conventional diagnosis before treating a patient with homeopathic remedies.

11.8 Willingness of Practitioners to be Regulated

Since 1992, the OHA has strived for the recognition of homeopathy in Ontario. To this end, it has:

- Set minimum practice standards for its members that are reviewed every five years.
- Developed a Code of Ethics for members.
- Conveyed the expectation that members will update their skills.
- Started work to establish Board examinations.

HPRAC consultations indicate that while there is not consensus on all issues, there is broad agreement that the status quo is not acceptable, and that there should be regulation of homeopathy in some form. Respondents see merit in codified entry to practise requirements, common practice standards and codes of conduct. There is also a significant recognition of the need for accountability and transparency, and that the public interest needs to be served.

Having said that, however, HPRAC notes the divergent opinions amongst homeopaths and that the OHA represents only approximately 40% of the homeopaths in Ontario. An inclusive transitional process leading to regulation must involve homeopathic practitioners in reaching consensus on a number of issues. On balance, HPRAC believes that homeopathic practitioners can be engaged in the development of the profession, and will accept and comply with regulation.

11.9 Collaborative Practice

Opportunities for collaborative practice between alternative and conventional medical practitioners are being explored. A major study on the integration of conventional and alternative medicine at the Toronto Hospital for Sick Children is nearing completion, and a conference on integrating conventional medicine with CAMs is scheduled for Edmonton in the spring of 2006. Where Ontario hospitals currently incorporate alternative therapies, they are generally culturally-specific and include traditional Chinese medicine, aboriginal medicine and naturopathic medicine.

Regulation under the *RHPA* would integrate new, consistent standards into the practice of homeopathy making collaborations more feasible in mainstream environments.

12. Options for Regulation of Homeopathy

Four options were considered as part of HPRAC's review. The status quo was considered and rejected. Homeopathy is demonstrably a system of medicine. As with any medical system, it has the potential to cause harm. Notwithstanding the debate about whether the practice can be supported by scientific evidence, a substantial number of people in Ontario are turning to homeopathy as an alternative to orthodox medicine. HPRAC is of the opinion that these factors rule out the status quo as an option.

Voluntary self-regulation was considered. HPRAC concluded that this system is not adequate. Entry and practice standards are unenforceable as are mechanisms to investigate and address complaints. Penalties are relatively ineffective and cannot prevent someone from continuing practice following sanctions imposed by a voluntary body. As well, success depends on a consensus among all practitioners. Finally, voluntary schemes typically suffer from funding challenges, which clearly impairs public protection through lack of enforcement and quality assurance.[39]

A suggestion was made to consider a two-tier scheme where classical homeopaths would continue to be unregulated while OHA members would pursue regulation under the *RHPA*. HPRAC finds that a system of patchwork regulation is not in the public interest.

HPRAC considered the option of stand-alone legislation outside of the *RHPA*. In essence, a stand-alone act would replicate the *RHPA*, which is the standard for regulation of health professionals. Regulation outside of the *RHPA* under a new act governing CAM's was considered as part of this option. This would permit homeopaths to co-locate with other CAM professions under a separate statute. Again, it is difficult to see the merit in establishing a parallel framework to the *RHPA*, particularly when the *RHPA* is also the regulatory mechanism for a number of professions that provide complementary and alternative therapies, including chiropractic, massage therapy and most notably the recent proposed addition of Traditional Chinese Medicine and acupuncture. Given the presence and merit of the existing regulatory framework, this option was rejected.

HPRAC is of the view that statutory regulation under the *RHPA* represents the best approach to providing public protection, quality care and public accountability for the homeopathy profession.

13. Controlled Acts

Based on extensive consultation with experts and stakeholders, HPRAC does not recommend that homeopaths be granted access to any of the controlled acts under the *RHPA*. There is general agreement that controlled acts are not required in the practice of homeopathy.

---

[39] Ibid, citing the Australian experience.

13.1 Request for exclusive rights to prescribing and compounding

Based on responses from intervenors, it is recommended that the OHA request for the controlled act of prescribing specific Homeopathic remedies as stated in the Homeopathic Pharmacopoeia of the U.S. (HPUS) and the compounding of remedies made from narcotics, biological poisons, venoms and diseased human tissue should not be identified as an exclusive act, part of a certification scheme, or an act restricted to a class within the profession of homeopathy. Rather, if regulated, a transitional council should work to incorporate these modalities into a formal standard of practice for regulated homeopaths.

14. Title Protection

HPRAC is concerned that anyone can represent him or herself as a homeopath, and this may present a risk to consumers, who may believe that the person providing homeopathic care is trained and qualified to do so. HPRAC is therefore recommending that the title "Registered Homeopath" be protected.

15. Conclusion

HPRAC concludes that the profession of homeopathy should be regulated under the *RHPA*, and that the title "registered homeopath" should be protected. HPRAC does not recommend that homeopaths be granted access to any controlled acts at this time.

16. The Opportunity: Joint Regulation of Homeopathy and Naturopathy

HPRAC's conclusion that homeopathy should be regulated as a profession under the *RHPA* presents an opportunity for the joint regulation of both homeopathy and naturopathy. HPRAC has twice recommended to the Minister that naturopathy be regulated under the *RHPA*, rather than under the *Drugless Practitioners Act, (DPA)* and it is an opportune time to move forward with joint regulation of these related professions.

There is a strong case for pursuing the regulation of homeopaths along with naturopaths under the *RHPA*. Naturopaths, as a profession, are advanced in terms of regulation and willing to be regulated under the *RHPA*, whereas homeopathy, as a profession, faces a number of challenges prior to formal regulation, including:

- Competency development leading to educational outcomes and practice standards;
- Identifying entry to practise requirements;
- Initiating complaints investigation and discipline processes;
- Developing quality improvement programs, and
- Working together to address many of the demands of regulation.

Naturopaths could be readily transitioned from regulation under the *DPA* and regulated under the *RHPA*. The *RHPA* is the contemporary legislative framework for regulating health professionals in Ontario and is the best means of providing public protection along with quality health care, and public accountability of the profession.

The *RHPA* already includes professions which are characterized as complementary or alternative and the Minister has recently proposed the regulation of Traditional Chinese Medicine and Acupuncture under the *RHPA*. The *DPA* has served its purpose, but is outdated legislation. While at one time the *DPA* regulated 15 health professions, today, it regulates only naturopaths.

Aligning homeopaths and naturopaths under a single professional College will help to address a number of issues, including accreditation of homeopathic educational programs, and addressing minimum qualifications for entry to practise for homeopaths in Ontario. As homeopaths transition towards full statutory regulation, there will be significant benefit from the experience of naturopathy, a profession that has been regulated for 80 years in the province. Moreover, there are close affiliations with naturopathy in that naturopaths receive some training in homeopathic principles as part of their education, and many naturopaths use homeopathic remedies in their practice. As part of the transition, homeopaths will need to attain high entry to practise standards that are comparable to those in the practice of naturopathy.

The membership of each profession, when combined, creates a desirable critical mass in order to support a professional College structure and there are benefits to be gained in a dual profession model of a single college.

17. Naturopathy in Ontario

17.1 Regulation of Naturopathy in Ontario

The history of the regulation of Naturopathy in Ontario is a lengthy one. The profession was first regulated in Ontario in 1923 through an amendment to the Ontario Medical Act, and since 1925 under the *Drugless Practitioners Act* has been governed by the Board of Directors of Drugless Therapy – Naturopathy (BDDT-N). The Ontario Association of Naturopathic Doctors (OAND) is a separate professional association representing naturopathic doctors.

Naturopaths have been seeking inclusion under the *RHPA* since the 1980s and participated extensively in the Health Professions Legislative Review (HPLR). Two separate reviews were undertaken in 1996 and 2001 by HPRAC, both concluding that the profession should be regulated under the *RHPA*.

In April, 2000, the Ontario Association of Naturopathic Doctors (OAND) and the Board of Directors of Drugless Therapy – Naturopathy (BDDT-N) made a joint submission to HPRAC. They proposed naturopaths be regulated as a new profession under the *RHPA* with the creation of a professional college and a profession-specific act. Their application provided a scope of practice statement for naturopathy and suggested title restrictions. It also recommended that naturopaths be given authority to perform a number of controlled acts.

The BDDT-N and the OAND have consistently advocated for inclusion of naturopathy under the *RHPA*.

Most recently, they specifically advocated that:

- The titles "Doctors of Naturopathic Medicine" and "Naturopathic Doctor" be protected and that all uses of the title "naturopathic" be reserved to members of the college;
- The use of the doctor prefix, provided the doctor's name is followed by one of the naturopathic titles, such as "Doctor of Naturopathic Medicine"
- Naturopaths be given access to seven controlled acts; and
- Naturopaths are not restricted to the use of natural health products as defined by the Natural Health Products Directorate (NHPD).

17.2 What is Naturopathy?

According to the BDDT-N, the practice of naturopathic medicine is the promotion of health, the assessment of the physical and mental condition of an individual, and the diagnosis, prevention and treatment of diseases, disorders and dysfunctions through education, common diagnostic procedures, and the integrated use of therapies and substances that promote the individual's inherent self-healing processes.

The American Association of Naturopathic Physicians (AANP) defines naturopathic medicine as a distinct system of primary health care – an art, science, philosophy and practice of diagnosis, treatment and prevention of illness. Naturopathic medicine is distinguished by the principles that underlie and determine its practice. These principles are based upon the objective observation of the nature of health and disease, and are continually reexamined in the light of scientific advances. Methods used are consistent with these principles and are chosen on the basis of patient individuality. Naturopathic physicians are primary health care practitioners, whose diverse techniques include modern and traditional, scientific and empirical methods.

Principles of Naturopathic Medicine[illegible]

1. **The Healing Power of Nature** – *Vies Medicare Nature*. NDs work to facilitate and augment the inherent, intelligent self-healing process in every person.
2. **Identify and treat the Causes** – *Tulle Causal*. Naturopathic doctors seek to identify and remove the underlying causes of illness, rather than to merely eliminate or suppress symptoms.

[illegible] Adapted from the AANP (American Association of Naturopathic Physicians) definition of Naturopathic Medicine, 1989

3. **First Do No Harm** – *Premium Non Nicer*. Naturopathic doctors follow three guidelines to avoid harming the patient
   - Using the least invasive or harmful methods necessary to diagnose and treat patients.
   - Avoid when possible the harmful suppression of symptoms
   - Acknowledge, respect and work with the individual's self-healing process

4. **Doctor as Teacher** – *Decree*. NDs emphasize education of all options and encourage self-responsibility for health.

5. **Treat the Whole Person** – Naturopathic doctors treat each patient by taking into account individual physical, mental, genetic, environmental and social factors. Encouraging patients to pursue their own spiritual development is another facet of total health.

6. **Prevention** – NDs recognize the importance of disease prevention through exploring heredity, risk factors and susceptibility to disease. Appropriate interventions are the key to creating and maintaining optimal health.

17.3 What is a Naturopath?

According to the information provided by the Ontario Association of Naturopathic Doctors (OAND) and BDDT-N, naturopathic doctors provide primary and adjunctive health care to people of all ages focusing on the rational use of natural therapies to support and stimulate healing processes. Naturopathic doctors promote health and prevent illness, and diagnose and treat disease in a manner consistent with the body of knowledge and standards of practice for the profession.[41]

Therapies used in naturopathic practice are:

- Botanical Medicine.
- Clinical Nutrition.
- Counselling.
- Homeopathic Medicine.
- Lifestyle Modification and Public Health.
- Mechanotherapy, including manipulation of the spine and extremities.
- Oriental Medicine and Acupuncture.
- Physical Therapeutic Procedures.

17.4 How the Public Receives Service

In March, 2006 there were 699 naturopaths registered with the BDDT-N. The majority of naturopaths are sole practitioners, while about 20 percent practice with other naturopathic doctors and close to 30 per cent practice with other health professionals. A small number of naturopathic doctors work in community agencies and institutional settings.

---

[41] April 2000 OAND/BDDT-N Application, Pg. 4

Naturopathic doctors provide diagnoses using standard Western medical diagnostic tools and procedures. They diagnose conditions for which diagnosis can be substantiated through: case history, physical examination, in-office functional measurements, in-office and common laboratory investigations, and diagnostic imaging.[12]

17.5 Education and Training

The Canadian College of Naturopathic Medicine (CCNM), located in Toronto, is the only school in Ontario that educates naturopaths. The naturopathic education program at the CCNM is a four-year program with three major areas of study:

- **Basic medical sciences** – anatomy, histology, physiology, biochemistry, microbiology and immunology,
- **Clinical disciplines** –physical and clinical diagnosis, differential and laboratory diagnosis, radiology, naturopathic assessment and orthopedics.
- **Naturopathic disciplines** – acupuncture and Oriental medicine, botanical and herbal medicine, clinical nutrition, homeopathic medicine, physical medicine, and lifestyle counselling.

Applicants must have completed three years towards a baccalaureate degree at a university in Canada or its equivalent. In 2004, there were approximately 500 students enrolled in the program.

Upon completion of the program, graduates take the Naturopathic Physician Licensing Examination (NPLEX) before registration by BDDT-N is granted. NPLEX is the standard naturopathic examination used by all licensing jurisdictions in North America. The NPLEX examination consists of five basic science exams in anatomy, physiology, pathology, biochemistry, microbiology and immunology (taken after the first two years of an approved naturopathic education program), as well as seven clinical exams and three additional elective exams in homeopathy, minor surgery and acupuncture. The Basic Science Exams assess whether the student has the foundation knowledge necessary for clinical training. The clinical exams are designed to measure clinical readiness – what the candidate needs to know to practise safely.[13]

The NPLEX examination is administered by the North American Board of Naturopathic Examiners (NABNE), which determines the qualifications of applicants to sit for the examination, administers the exams, and reports results to regulatory authorities. Regulatory agencies such as BDDT-N grant authority to NABNE to be the examining body, and rely on it in determining entry to practise qualifications. Two members of the five-member Board are from Canada. At the current time, all 13 states and five provinces that regulate the naturopathic profession recognize NPLEX to ensure candidates meet high minimum competency standards.

---

[12] April 2000 OAND/BDDT-N Application, pg. 5
[13] NPLEX Clinical Examinations Study Guide, 1999, pg. 1

In addition to the NPLEX, the BDDT-N administers Ontario-based examinations in acupuncture, homeopathy and Ontario jurisprudence, as well as practical examinations in Instrumentation, Acupuncture and Manipulation.[44]

The Council on Naturopathic Medical Education (CNME) is the recognized accreditation body for naturopathic educational programs in North America. It has been recognized by the U.S. Secretary of Education since 1987 as the national accreditor for programs leading to the Doctor of Naturopathic Medicine degree. In 1991, the Council broadened its geographic scope to include accreditation in Canada.[45]

The Council members are also the corporation's Board of Directors. They determine policy and procedures, conduct evaluations of and monitor colleges and programs, and make decisions about accreditation and candidacy.[46] There are currently four accredited naturopathic Colleges in North America, including the Canadian College of Naturopathic Medicine (CCNM) in Toronto.

18. The OAND/BDDT-N Proposal Requesting Regulation

As part of the continued efforts to see naturopaths included under the *RHPA*, in April 2000, the OAND and BDDT-N made a joint submission to HPRAC requesting regulation of naturopaths under the *RHPA* and proposed a defined scope of practice statement for naturopathy:

> The practice of naturopathic medicine is the promotion of health, the assessment of physical and mental condition of an individual, and the diagnosis, prevention and treatment of diseases, disorders and dysfunctions through education, common diagnostic procedures, and the integrated use of therapies and substances that promote the individual's inherent self-healing process.

The OAND and BDDT-N requested that eight controlled acts be authorized to their profession. They claimed that these acts were necessary in order to accurately capture the scope of practice of naturopathic doctors as they currently practice under Ontario Regulation 107/96, Section 10, which exempts naturopaths from Section 27(1) of the *RHPA* for activities within their scope of practice. Further, the applicants indicated that the following titles should be restricted to registered members:

---

[44] http://www.boardofnaturopathicmedicine.on.ca/pdf/2006_Feb_InfoBooklet_Application_rev.pdf
[45] *Handbook of Accreditation for Naturopathic Medical Colleges and Programs* (1998 Edition), pg. 2
[46] Ibid., pg. 2

- Naturopathic Doctor.
- Doctor of Naturopathy.
- Doctor of Naturopathic medicine.
- Naturopath.
- Abbreviation "N.D."

They also requested that naturopathic doctors be entitled to use the prefix "Dr." as they do in other regulated jurisdictions.

Two separate HPRAC reviews in 1996 and 2001 recommended regulation of naturopaths under the *RHPA*. In 2001, HPRAC recommended that naturopaths be regulated as a new profession in a College of Naturopaths. The Advisory Council also recommended that "Naturopath", "Naturopathic Doctor" and "Doctor of Naturopathy" be protected titles, and that naturopaths be granted access to seven of the eight requested Controlled Acts, with several limitations.

Recently, the BDDT-N has responded to requests for information from HPRAC and, in the process, has updated its 2001 application for regulation, and reconfirmed its will to be regulated. Its response indicated a willingness to accept a joint college, a profession-specific act, access to seven controlled acts, and that naturopaths not be restricted to the use of natural health products as defined by the NHPD.

19. Factors Informing HPRAC's Recommendation to Regulate Naturopaths

19.1 Risk of Harm

Many consumers who use the services of a naturopath do so in the belief that treatments are natural and are, therefore, harmless. Direct harm may occur from adverse reactions to preparations and from misapplication. Indirect harm can occur from misdiagnosis and delay of effective therapies.

The risk of harm from botanical medicines can be significant. The risks identified in HPRAC's 2001 report are still relevant today. There is the risk of patients consuming inappropriate doses or the danger of herb-herb or herb-drug interactions. Some herbal remedies are inherently dangerous (e.g. aristolochia fangchi[47] and comfrey[48]) while many others can be dangerous if taken in inappropriate doses (e.g. blue cohosh[49]) or with other herbal products or drugs (e.g. St. John's Wort[50]). The Federal government's initiative to regulate natural health products and develop a list of restricted or controlled natural health products is a signal of the potential risk of harm from these products.

The National Institutes of Health (NIH) Consensus Panel on Acupuncture has concluded that while the instances of adverse events in the practice of acupuncture are extremely low, there have been rare occasions of life-threatening situations (e.g. pneumothorax) and as a result, appropriate safeguards for patient protection are essential.[51]

---

[47] Greensfelder, 2000.

[48] Chandler et al. pg. 83

[49] Chandler et al. pg. 58

[50] Chandler et al. pg. 200

19.2 Conflict of Interest

Concerns have been expressed regarding potential conflict of interest when a practitioner both prescribes or recommends a treatment, and also provides the medication to the patient. Some naturopaths provide remedies to their patients. This matter can be addressed by regulation and standards of practice for the profession.

19.3 Qualifications and Accreditation

HPRAC notes significant gains in the academic rigour surrounding the core body of knowledge for the profession. There is an increasing amount of research being published in peer-reviewed journals and there is evidence that the academics are scrutinizing curricula on this basis.

Toronto is home to one of the four accredited naturopathic colleges in North America. Based on its review of the curriculum, and the fact that the College has been accredited by a recognized North American accreditation body, HPRAC is of the view that the educational program for naturopaths in Ontario (and Canada) is of a sufficient quality to ensure the appropriate education and training of naturopathic doctors.

19.4 Title Protection

The BDDT-N recently clarified title issues for HPRAC. In its 2001 Report, HPRAC referred to NDs as either naturopaths or naturopathic doctors and referred to the practice as either naturopathy or naturopathic medicine. According to the BDDT-N, the terms that are used in regulated jurisdictions throughout North America are naturopathic doctor and naturopathic medicine. In some jurisdictions 'naturopath' is used to denote a separate category of membership for practitioners who have not met the more stringent requirements that are in place for NDs in Ontario. These standard entry to practise requirements are the same for all regulated jurisdictions in North America: the Naturopathic Physicians Licensing Examinations (NPLEX). The BDDT-N indicated that 'Naturopath' is also a term used by individuals in unregulated Canadian jurisdictions who have inconsistent and substandard education and/or training. Within the profession, the term 'naturopathy' is considered to be antiquated and naturopathic medicine is the commonly used and accepted description of the practice of NDs.

19.5 Supervision

The majority (55 per cent) of naturopathic practitioners work alone. For this group there is little if any supervision. There is no mechanism to oversee skills or standards of care or provide peer mentoring.

---

[51] NIH consensus statement on Acupuncture, pg. 14

19.6 Willingness of Practitioners to be Regulated

Naturopaths in Ontario have repeatedly attempted to be regulated under the *RHPA*. The OAND and BDDT-N submitted a proposal for regulation in April 2000. Further OAND and BDDT-N representations in 2005 and 2006 reaffirm that the profession is willing to be regulated.

A recent Internet survey[32] of practitioners regulated by the BDDT-N and undertaken by a coalition of the BDDT-N, the OAND, the Canadian Association of Naturopathic Doctors and the Canadian College of Naturopathic Medicine indicated that:

- Three quarters of members surveyed said that current regulation is not adequate;
- Three-quarters of members surveyed said that it is very important to have naturopathic doctors regulated under *RHPA*; and 95 percent of members surveyed said that it was somewhat or very important that naturopaths be regulated under the *RHPA*;
- Close to 4 out of 5 members endorse the move to regulation under the *RHPA*.

20. Deficiencies of the *Drugless Practitioners Act*

The profession of Naturopathic Medicine is currently regulated under the *Drugless Practitioners Act*, which was promulgated in 1925, more than 80 years ago. Ten years ago, the HPRAC Report on Naturopathy identified many of the challenges of regulating a health profession under that Act, including:

- The *DPA* and Regulation 278 make no provisions for the continuing competency of registrants. The BDDT-N has attempted to deal with this issue by developing a policy that requires a minimum amount of continuing education, however there is nothing in the Act or regulations that provides the Board with the authority to enforce the policy.

- The *DPA* has no provisions for other 'quality assurance' initiatives such as a portfolio program, practice review or remediation of behaviour of a sexual nature.

- There are no specific provisions in the *DPA* to prevent and respond effectively to sexual abuse.

- The investigative powers for misconduct, incompetence and incapacity matters that are found under the *RHPA* (e.g. right of access to offices and records, summonsing powers, search warrants, board of inquiries) do not exist under the *DPA*.

---

[32] Survey conducted February 21- March 3, 2006

- The *DPA* does not provide viable options for dealing with malpractice and incompetence.

- If a concern arises as to the disposition of a complaint, the only appeal process afforded patients under the *DPA* is application for judicial review.

- The only disciplinary options available under the *DPA* for registrants following a finding of misconduct are suspension or revocation of registration.

- There are no options at the disciplinary level for such things as remedial education, practice restrictions or mandatory monitoring and supervision.

- There are no regulations to explicitly allow for delegation by Naturopathic Doctors to other regulated health professionals.

In 2006, HPRAC reiterates its view that the *DPA* is an inappropriate statutory vehicle for the regulation of a health profession.

21. Summarizing the Case for Regulation

Naturopathic doctors have well-developed standards, qualifications, standards of practice and complaints, investigation and discipline processes. There is a clear body of knowledge. One of the four internationally-accredited schools is in Ontario. Naturopaths are regulated in many jurisdictions. The profession has consistently shown a willingness to be regulated under the *RHPA*.

There have now been two separate HPRAC reviews recommending regulation. The reviews concluded that there is significant risk of harm, both direct and indirect from the practice of naturopathy. The *Drugless Practitioner's Act* is not equipped with sufficient public safety and accountability provisions to address the question of harm or ensure the public interest is protected.

22. Conclusion

Where the *DPA* falls short, the *RHPA* offers a comprehensive regulatory framework for the regulation of health professionals. It is, therefore, in the public interest to regulate the profession of naturopathy under the *RHPA*. Further to its earlier determination, HPRAC concludes that the profession of naturopathy should be regulated in a joint college with homeopathy under the *RHPA*.

23. Co-Regulation of Homeopathy and Naturopathy

HPRAC sees clear links between the principles and practices of naturopathy and homeopathy. Accordingly, the Advisory Council recommends the co-regulation of homeopathy and naturopathy in a joint college under the *RHPA*. It is HPRAC's view that the two professions should be regulated through a single Act and be governed by a single college council that provides opportunities for profession-specific activities and representation of each profession along with members appointed by the Lieutenant Governor in Council.

HPRAC sees many advantages to this, not the least of which are cost efficiencies that will accrue to both professions that have individually a relatively small body of membership. The membership of each profession, when combined, creates a desirable critical mass in order to support a professional college structure. The College of Audiologists and Speech Language Pathologists provides a solid precedent for successful regulation of two professions under one college. Regulation under one college also enhances opportunities for collaboration between the professions.

23.1 Scopes of Practice

As a result of HPRAC's consultation process and additional research and advice, HPRAC recommends:

- That the scope of practice for naturopathy should be:

  > The practice of naturopathic medicine is the promotion of health, the assessment of the physical and mental condition of an individual, and the diagnosis, prevention and treatment of diseases, disorders and dysfunctions through the integrated use of natural therapies and natural medicines that promote the individual's inherent self-healing mechanisms.

- That the scope of practice for homeopathy should be:

  > The practice of Homeopathy is the assessment of body system disorders through homeopathic techniques and treatment using homeopathic remedies to promote, maintain or restore health.

23.2 Controlled Acts

Homeopathy

HPRAC does not recommend that homeopaths be granted access to any controlled acts at this time.

Naturopathy

In 2001, HPRAC made a series of recommendations with respect to the controlled acts which ought to be authorized to naturopathic doctors. In 2006, the BDDT-N and the OAND provided additional information and clarification to HPRAC to supplement their previous requests for regulation under the *RHPA*. HPRAC has reviewed its 2001 conclusions, and makes the following recommendations.

- **Communicating a Diagnosis**

  In 2001, HPRAC recommended that naturopathic doctors be authorized to communicate a diagnosis as follows:

> That the controlled act of communicating a diagnosis be authorized to naturopaths subject to the limit that the diagnoses that can be communicated are those which:
>
> - are reached through considering the individual's history the findings of a comprehensive health examination, and where necessary, the results of laboratory tests and other investigations that the member is authorized to perform; and
>
> - are reached after complying with mandatory indicators for referral and/or consultation to be developed by the naturopathy profession's regulatory College.

In 2006, HPRAC continues to support the recommendation made in 2001.

- **Procedure Below the Dermis**

  In 2001, HPRAC recommended that the controlled act of performing a procedure on tissue below the dermis be authorized to naturopaths as follows:

  > Performing a procedure on tissue below the dermis for the purposes of venipuncture, skin pricking and needle acupuncture.

  HPRAC continues to support the 2001 recommendation.

- **Moving the Joints of the Spine**

  In 2001, HPRAC recommended that naturopaths be authorized the controlled act of moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust with the exception of cervical manipulation; and that a regulation on mandatory consultation and referral be developed by the regulatory body and put into place prior to the enactment of a *Naturopathy Act*.

  The BDDT-N has indicated to HPRAC that manipulation has always been a part of the scope of practice of naturopathic doctors, and to date, it has not received any reports of incidents with respect to its performance. Furthermore, the BDDT-N reported that there are standards in place for the safe practice of this modality as well as continuing education requirements. HPRAC notes that manipulation is within the scope of practice of naturopaths in other jurisdictions in North America.

  HPRAC also notes that the BDDT-N currently requires each candidate for registration to pass NPLEX examinations in physical therapy and diagnosis as well as a practical examination in spinal manipulation, including manipulation of the cervical spine. HPRAC is of the view that any limitations on the practice of cervical manipulation should be established by the college through regulations under the act.

Therefore, HPRAC recommends that naturopaths be granted access to the controlled act of "moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust".

- **Administering a Substance**

The 2001 HPRAC report recommended that naturopaths be authorized the controlled act of administering a substance by injection or inhalation as follows:

> Administering a substance by inhalation or injection as designated by regulation.

In 2001, HPRAC recommended that naturopaths be restricted in the administration of substances that were considered drugs in that they should not "administer a substance that is a drug unless that substance is prescribed by another regulated health professional who has authority to prescribe". This recommendation centred on the understanding that the federal government would be developing a list of restricted or controlled natural health products and the substances used by naturopaths would be transferred to this list. However, this list has not yet materialized.

Consequently, HPRAC recommends that naturopaths be granted access to the controlled act as follows:

> Administering a substance by inhalation or injection as designated by regulation.

- **Putting an instrument, hand or finger into openings of the body**

In 2001, HPRAC recommended that:

> Naturopaths be authorized the controlled act of putting an instrument, hand or finger into openings of the body as follows:
>
> - beyond the opening of the urethra to obtain a sample for cultures
> - beyond the labia majora but not beyond the cervix
> - beyond the anal verge but not beyond the rectal-sigmoidal junction

In 2006, HPRAC reaffirms its 2001 recommendations.

- **Forms of Energy**

  HPRAC recommends that naturopaths be authorized the controlled act of applying or ordering the application of a form of energy as follows:

  > Ordering diagnostic ultrasound and other forms of energy used for diagnostic purposes as designated by regulation.

  HPRAC notes that additional forms of energy may be proposed during regulation development process.

- **Prescribing, dispensing, selling and/or compounding drugs and natural products**

  In 2001, HPRAC's recommendation on naturopaths prescribing drugs was based on the understanding that the federal government would be developing a list of restricted or controlled natural health products. HPRAC felt that naturopaths would logically require access to substances on this list and therefore made a recommendation for a new controlled act of "prescribing, dispensing, selling or compounding natural health products". However, in the intervening five years, the Natural Health Products Directorate and the Natural Health Product (NHP) regulations came into force in January, 2004. The regulations apply only to products that are considered safe for over the counter use by the public. According to the BDDT-N:

  > There are a number of "natural health products" excluded from the NHP regulations that have traditionally been prescribed, compounded and/or dispensed safely and effectively by NDs, and/or that have been or may be removed from the public realm due to safety concerns. As stated at the Health Canada Symposium on herb/drug/food interactions February 9 & 10, 2006, the Natural Health Products Directorate (NHPD) is now considering the creation of a separate schedule for natural health products that are considered to be of higher risk. This is something the naturopathic profession has been advocating for since the inception of the regulations. There are botanical medicines and other natural health products that should only be used under the advice and supervision of a health care professional who is educated and trained in their use. It is crucial that the diagnostic, therapeutic and emergency substances requested by naturopathic doctors be available for use in the care of their patients.[51]

  HPRAC has also learned that nine of twelve of the regulated jurisdictions in the USA that regulate naturopathy permit naturopathic doctors the authority to prescribe or use drugs.

---

[51] BDDT-N Documentation to HPRAC, March, 2006

HPRAC finds that optimal care cannot be offered to patients unless naturopathic doctors have access to substances consistent with naturopathic practice. Therefore, HPRAC recommends:

> That naturopaths be authorized to prescribe, dispense, sell and/or compound drugs that are consistent with naturopathic practice, as prescribed in regulations.

- **Allergy Testing**

HPRAC recommends, as it did in 2001, that the allergy testing controlled act not be authorized to naturopaths.

23.3 Professional Titles

HPRAC recommends that:

Homeopathy:

- The use of the title "Registered Homeopath", a variation or abbreviation or equivalent in another language, should be restricted to members of the college; and
- That a person who is not a member of the college should not represent him or herself as a person who is qualified to practise homeopathy in Ontario.

Naturopathy:

- The use of the title "Naturopathic Doctor", "Doctor of Naturopathic Medicine" and "naturopath" a variation or abbreviation or equivalent in another language, should be restricted to members of the college; and
- That a person who is not a member of the college should not represent him or herself as a person who is qualified to practice naturopathy or naturopathic medicine in Ontario.

24. Transition to Regulation

In preparation for full regulation of homeopathic and naturopathic professionals in a college under the *RHPA*, transitional activities will be required. HPRAC recommends that a structured, multi-year transition process specific to naturopathy and homeopathy should be set out in the legislation, with a Transitional Council for Homeopathy and a Transitional Council for Naturopathy. These Councils will develop and implement profession-specific high minimum qualifications and standards for the practice and would jointly undertake some activities.

Given that naturopaths have been a regulated profession for over 80 years a shorter transition period is required for full regulation under the *RHPA*. To that end a time frame of no less than one year should be established for the completion of the naturopathy Transitional Council functions. In the face of the challenges in the profession of homeopathy, a time frame of three years is likely required for completion of the homeopathy Transitional Council functions.

There is no reliable accreditation scheme for homeopathy in Canada and there is wide variance in the educational programs offered by different homeopathic schools across Canada. As part of the transition, homeopaths will need to attain similar standards as other regulated health professions in terms of quality of education and qualifications for entry to practise.

24.1 Homeopathy: Transitional Council

HPRAC recommends that the Transitional Council for Homeopathy should be composed of a Chairperson, Vice-Chair and a Transitional Council appointed by the Lieutenant Governor in Council, on the recommendation of the Minister of Health and Long-Term Care. The Transitional Council would, in conjunction with the Transitional Council for Naturopathy, appoint a Registrar.

In addition to the Chair and Vice-Chair, the Transitional Council for Homeopathy should be composed of at least six and no more than nine persons who are unregulated practitioners of homeopathy; at least five and no more than eight public members; and at least three persons nominated by the Ontario College of Pharmacists (OCP), College of Physicians and Surgeons of Ontario (CPSO), and the College of Chiropractors of Ontario (CCO).

The purpose of including representatives from the CPSO, CCO and the OCP on the Transitional Council is to ensure their involvement and assistance in the identification and development of competencies leading to educational standards, entry to practise requirements, general practice standards, complaints investigation and discipline processes for the practice of homeopathy. They have regulatory expertise to contribute to this effort, and are themselves tasked with these same responsibilities.

It is not contemplated that representatives of the existing Colleges would become members of the permanent council of the college, and their appointments would terminate when the work of the Transitional Council is completed.

The Homeopathy Transitional Council should immediately identify and develop:

- A list of practicing Homeopaths – including the names of persons who practice Homeopathy, their education and training, and billing practices;
- High minimum qualifications, including educational and equivalency standards;
- Entry to practise requirements;

- Classes of registration;
- General standards of practice for homeopathy;
- Quality assurance and continuing competency programs for the practice of homeopathy;
- Standards for mandatory consultation and referral; and
- Any matter related to the regulation of homeopathy which the Transitional Council considers appropriate.

The Transitional Council for Homeopathy would have the authority to accept and process applications for registration, charge application fees and issue certificates of registration.

24.2 Naturopathy: Transitional Council

It is anticipated that transitional activities for the profession of naturopathy can accomplish the goal of regulation under the *RHPA* in one year. The Transitional Council for Naturopathy should be composed of a Chair, Vice-Chair and a Transitional Council appointed by the Lieutenant Governor in Council on the recommendation of the Minister of Health and Long-Term Care. The Transitional Council, in conjunction with the Transitional Council for Homeopathy, should appoint a Registrar.

In addition to the Chair and Vice-Chair, the Transitional Council for Naturopathy should be composed of at least six and no more than nine persons who are currently regulated practitioners of Naturopathy; at least five and no more than six public members; and at least three representatives nominated by the Ontario College of Pharmacists (OCP); the College of Chiropractors of Ontario (CCO), and the College of Physicians and Surgeons of Ontario (CPSO).

It is not contemplated that representatives of the existing Colleges would become members of the permanent council of the college, and their appointments would terminate when the work of the Transitional Council is completed.

The Naturopathy Transitional Council should move immediately to develop:

- A list of naturopaths – including the names of persons who practice naturopathy, their education and training, and billing practices;
- High minimum qualifications for entry to practise, including equivalency standards;
- General standards of practice for the practice of naturopathy;
- Quality assurance and continuing competence programs for the profession of naturopathy;
- Classes of registration for the profession of naturopathy;

- Standards of practice for the profession of naturopathy;
- Standards for mandatory consultation and referral for the profession of naturopathy; and
- Any matter related to the regulation of naturopathy which the Transitional Council considers appropriate.

The Transitional Council for Naturopathy would have the authority to accept and process applications for registration, charge application fees and issue certificates of registration.

24.3 Joint Functions of the Transitional Councils

HPRAC believes that it is important that the Transitional Councils immediately and jointly undertake initial activities, and that their joint activities should include:

- Appointment of a Registrar;
- Development of complaints, investigations and discipline processes;
- Development of College by-laws;
- Development of advertising, conflict of interest, and record-keeping regulations;
- Development of codes of ethics and professional conduct.

25. Recommendations

HPRAC recommends to the Minister:

1. That homeopaths and naturopaths should be regulated under the *Regulated Health Professions Act, 1991.*
2. That a College of Naturopaths and Homeopaths of Ontario should be established.
3. That the Council of the College should be composed of (a) at least six and no more than nine persons who are members elected in accordance with the College's by-laws; (b) at least five and no more than eight persons appointed by the Lieutenant-Governor-in-Council who are not members of the College, another College or Council under the *RHPA*.
4. That the Council should have a President and Vice-President elected annually by Council from among its members.
5. That every member of the College who practices homeopathy and every member of the College who practices naturopathy or resides in Ontario and who is not in default of payment of the annual membership fee should be entitled to vote in an election of members of the Council.

6. That the scope of practice for naturopathy should be:

   The practice of naturopathic medicine is the promotion of health, the assessment of the physical and mental condition of an individual, and the diagnosis, prevention and treatment of diseases, disorders and dysfunctions through the integrated use of natural therapies and natural medicines that promote the individual's inherent self-healing mechanisms.

7. That the scope of practice for homeopathy should be:

   The practice of Homeopathy is the assessment of body system disorders through homeopathic techniques and treatment using homeopathic remedies to promote, maintain or restore health.

8. That homeopaths should not be authorized to perform any controlled acts.

9. HPRAC recommends the following regarding controlled acts for the profession of naturopathy:

   - **Communicating a Diagnosis**

     That the controlled act of communicating a diagnosis be authorized to naturopaths subject to the limit that the diagnoses that can be communicated are those which:

     - are reached through considering the individual's history the findings of a comprehensive health examination, and where necessary, the results of laboratory tests and other investigations that the member is authorized to perform; and

     - are reached after complying with mandatory indicators for referral and/or consultation to be developed by the naturopathy profession's regulatory College.

   - **Procedure Below the Dermis**

     That naturopaths be authorized to performing a procedure on tissue below the dermis for the purposes of venipuncture, skin pricking and needle acupuncture.

   - **Moving the Joints of the Spine**

     That naturopaths be granted the controlled act of "moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust".

   - **Administering a Substance**

     That naturopaths be authorized to administer a substance by inhalation or injection as designated by regulation.

- **Putting an instrument, hand or finger into openings of the body**

  That naturopaths be authorized the controlled act of putting an instrument, hand or finger into openings of the body as follows:

  - beyond the opening of the urethra to obtain a sample for cultures
  - beyond the labia majora but not beyond the cervix
  - beyond the anal verge but not beyond the rectal-sigmoidal junction

- **Forms of Energy**

  That naturopaths be authorized the controlled act of applying or ordering the application of a form of energy as follows:

  Ordering diagnostic ultrasound and other forms of energy used for diagnosticpurposes as designated by regulation.

- **Prescribing, dispensing, selling and/or compounding drugs and natural products**

  That naturopaths be authorized to prescribe, dispense, sell and/or compound drugs that are consistent with naturopathic practice, as prescribed in regulations.

- **Allergy Testing**

  That the allergy testing controlled act not be authorized to naturopaths.

10. That the use of the title "Registered Homeopath", a variation or abbreviation or equivalent in another language, should be restriced to members of the college.

11. That a person who is not a member of the college should not represent him or herself as a person who is qualified to practise homeopathy in Ontario.

12. The use of the title "Naturopathic Doctor", "Doctor of Naturopathic Medicine" and "naturopath" a variation or abbreviation or equivalent in another language, should be restricted to members of the college; and

13. That a person who is not a member of the college should not represent him or herself as a person who is qualified to practice naturopathy or naturopathic medicine in Ontario.

14. That the Lieutenant-Governor-in Council, on recommendation of the Minister, should appoint, for a period of three years, a Transitional Council for Homeopathy, a Chair and Vice-Chair.

15. That the Lieutenant-Governor-in Council, on recommendation of the Minister, should appoint, for a period of one year, a Transitional Council for Naturopathy, a Chair and Vice-Chair.

16. That the Transitional Council for Homeopathy should be composed of a Chair; a Vice-Chair; at least six and no more than nine persons who are currently unregulated practitioners of homeopathy; at least three persons who are nominated by the College of Physicians and Surgeons of Ontario, the College of Chiropractors of Ontario and the Ontario College of Pharmacists; and at least five and no more than eight persons who are not currently unregulated practitioners of homeopathy, members of a regulated College or Council under the *RHPA*.

17. That the Transitional Council for Naturopathy should be composed of a Chair; a Vice-Chair; at least six and no more than nine persons who are currently members registered with the Board of Directors of Drugless Therapy – Naturopathy; at least three persons who are nominated by the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists, and the College of Chiropractors of Ontario; and at least five and no more than eight persons who are not currently members registered with the Board of Directors of Drugless Therapy – Naturopathy, members of a regulated College or Council under the *RHPA*.

18. That the Transitional Council for Homeopathy and the Transitional Council for Naturopathy should together and immediately move to:

    a) Appoint a Registrar;

    b) Develop and implement complaints, investigations and discipline processes;

    c) Develop College by-laws, including by-laws respecting the election of members to Council;

    d) Develop advertising, conflict of interest, and record-keeping regulations;

    e) Develop administrative procedures; and

    f) Develop codes of ethics and professional conduct.

19. That the Transitional Council for Homeopathy and the Transitional Council's committees should have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

20. That the Transitional Council for Naturopathy and the Transitional Council's committees should have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

21. That the Transitional Council for Homeopathy and its employees and committees should have the authority to do anything that is necessary or advisable until the Council is established.

22. That the Transitional Council for Naturopathy and its employees and committees should have the authority to do anything that is necessary or advisable until the Council is established.

23. That upon appointment of its members, the Transitional Council for Homeopathy should move immediately to develop:

    a) A list of currently unregulated homeopaths, including the names and addresses of persons who practice homeopathy, their education and training, and billing practices, as well as the form of homeopathy that each practices;

    b) High minimum qualifications for the practice of homeopathy;

    c) The educational qualifications and equivalency standards to address the registration of currently unregulated practitioners of homeopathy;

    d) Classes of registration for the practice of homeopathy

    e) General standards of practice for homeopathy;

    f) Standards for mandatory consultation and referral;

    g) Quality assurance and continuing competence programs for the practice of homeopathy; and

    h) Any matter related to the regulation of homeopathy which the Transitional Council considers appropriate.

24. That upon appointment of its members, the Transitional Council for Naturopathy should move immediately to develop:

    a) A list, including the names and addresses, of persons who are currently registered with the Board of Directors of Drugless Therapy – Naturopathy, their education and training, and billing practices as well as the form of naturopathy that each practices;

    b) High minimum qualifications for the practice of naturopathy;

    c) The educational qualifications and equivalency standards to address the registration of currently regulated and unregulated practitioners of naturopathy;

    d) Classes of registration for the practice of naturopathy;

    e) General standards of practice for naturopathy;

f) Standards for mandatory consultation and referral;

g) Quality assurance and continuing competence programs for the profession of naturopathy; and

h) Any matter related to the regulation of naturopathy which the Transitional Council considers appropriate.

25. That subject to the approval of the Lieutenant-Governor-in-Council, and with prior review of the Minister, the Council of the College of Naturopaths and Homeopaths should be authorized to make regulations

    - Prescribing high minimum qualifications for the practice of homeopathy and for the practice of naturopathy;
    - Prescribing and governing the therapies involving the practiceof the profession of homeopathy and the profession of naturopathy and prohibiting other therapies;
    - Adding protected titles; and
    - Any matter relevant to the profession of homeopathy and/or the practice of homeopathy; and any matter relevant to the profession of naturopathy and/or the practice of naturopathy.

26. That the *Drugless Practitioners Act* should be repealed.

REGULATION OF KINESIOLOGY

The Minister's Question

In his letter of referral of February 7, 2005, the Minister requested advice from the Health Professions Regulatory Advisory Council (HPRAC) on:

> Whether kinesiologists should be regulated under the *[Regulated Health Professions Act,1991] RHPA*, including what their scope of practice should be, what controlled acts, if any, they should be authorized to perform, and any protected titles, and whether it is appropriate for kinesiologists to be regulated under an existing profession-specific Act.[1]

In its review of the question, HPRAC undertook to examine two additional questions:

> What role, if any, do kinesiologists play in the delivery of health care services in Ontario? and
> Are kinesiologists representative of a move to a wellness-based model of health care in Ontario?

HPRAC's Response

After investigating the work of kinesiologists as primary care providers in the prevention, treatment and rehabilitation of musculoskeletal conditions, HPRAC's central recommendation is that kinesiology should be regulated in Ontario under the *RHPA*.

The health care system in Ontario is evolving to include the concept of wellness, health promotion and illness prevention. Kinesiologists are playing a growing and increasingly important role in maintaining the health of individuals, in rehabilitation, and in assessing the needs of people with a variety of conditions. HPRAC brought this context to the investigation of regulation of kinesiologists.

1. The Consultation Process

At the outset of an extensive consultative process with stakeholders, HPRAC invited submissions from private citizens, kinesiology practitioners, regulated health professions, and professional associations. Thirty-four written submissions were received.[2] In addition, HPRAC held three focus groups with employers of kinesiologists and representatives of Ontario university kinesiology programs. One took place in Toronto and two in London. These were supplemented with a number of key informant interviews as well as literature and jurisdictional reviews.

---

[1] Minister's Referral Letter, February 2005, Appendix A

[2] Submissions are posted on the HPRAC website, www.hprac.org

2. Background

2.1 What is a Kinesiologist?

In brief, kinesiologists assess human movement and implement strategies to promote the general function and health of the public as well as to help prevent injury and disease.[3]

Examples of the health-care related roles that kinesiologists fill include:

- Rehabilitation providers in hospital rehabilitation units, clinics or private sector rehabilitation settings. Clients groups include musculoskeletal, cardiac and neurological rehabilitation patients, and vehicle and workplace accident victims.
- Functional assessment specialists or exercise therapists in long-term care homes. Services include assessing residents' transfer capacity (ability to get in and out of bed), teaching proper transfer skills to residents, and designing and implementing exercise regimes for residents.
- Ergonomists in the workplace or home. Services include assessing and analyzing individuals to determine ways of reducing or eliminating the risk of workplace injury, or promoting re-adaptation into the environment. Clients include individuals, employees and their employers, and insurance firms.
- Personal trainers and exercise therapists. Services include health promotion and well-being through exercise and education and designing exercise programs for clients. This role is expanding to include program design for individuals with more complex chronic conditions. Clients include individuals, corporations and sports medicine clinics.

2.2 Roles of Kinesiologists

Cardiac Rehabilitation

A cardiac rehabilitation provider or therapist may perform cardiovascular stress tests, monitor heart function using Electrocardiogram (ECG), heart rate measures, blood pressure, and assess cardiopulmonary physiology. A cardiac therapist provides exercise therapy programs designed to restore and maintain function.

---

[3] The Ontario Kinesiology Association's Submission for Regulation under the *RHPA*, April 2005

Insurance

In the insurance sector, kinesiologists may independently or as part of a team work in one of the following roles:

1. As an independent assessor or evaluator performing homesite assessments, attendant care needs assessments, ergonomic assessments, functional ability evaluations, future care cost analyses, life care planning assessments, and impairment evaluations and ratings. Assessments or evaluations may be performed on behalf of the insurer or the claimant.

2. As a therapeutic rehabilitation provider in a clinical, home or exercise facility performing test of function, creating treatment plans and programs, providing therapeutic exercise programs, work conditioning and hardening programs and modalities treatments, and providing education.

3. As a return-to-work manager or coordinator creating graduated and modified return-to-work plans that consider the claimant's functional status in relation to the work requirements. They coordinate the interested parties and monitor the progress of the return-to-work plan, making changes as needed to ensure that the client returns to work. They may also provide job coaching to the claimant to ensure that clients use good body mechanics and pacing as they return to work.

4. As a case manager overseeing the claimant's file to ensure coordination of treatment, assessments and return-to-work efforts. The case manager liaises between all stakeholders working towards resolution of the claim.

5. As an adjudicator or adjuster on behalf of the insurer administering the benefits in the claim, and reviewing and handling any and all documentation. They work to meet the terms of the regulations and contract.

6. As a medical-legal evaluator of medical information, data, and reports as they pertain to a claim for benefits, and advising either the insurer or claimant about how the information impacts the claim.

Long-Term Care

A kinesiologist's role in long-term care is usually in the provision of restorative care. Restorative care, a mandated program of the Ministry of Health and Long-Term Care (MOHLTC), aims to re-establish physical function when residents of long-term care homes experience rapid physical decline after admission. Examples of restorative care programs are:

1. Walking programs. Residents participate in a progressive walking program and are encouraged to walk to activities of daily living rather than be wheeled in a wheelchair.

2. Individual exercise programs. Restorative staff is responsible for visiting residents and assisting them to complete strengthening and

range of motion exercises designed to improve strength, prevent contractures, and improve circulation to limbs that may not otherwise be activated.

3. Group exercise programs. Restorative staff is responsible for leading group exercise programs that focus on strength, flexibility and balance, the core components of mobility.

4. Restorative dining. Restorative staff is responsible for working with a small group of residents at meals on re-developing self-feeding skills. Restorative staff liaises with other health professionals to overcome barriers to self-feeding by modifying utensils, food textures and providing coaching on swallowing technique.

5. Physical therapy. Restorative staff is responsible for working with the home's physical therapist to implement exercises on a one-to one basis.

Kinesiologists can play one of two roles in the areas noted above. Some work as activity directors who create and oversee restorative care programs and one-on-one exercise plans for residents. In this role, they oversee other staff to ensure that programs meet residents' social, creative, emotional and physical needs. Others work in long-term care homes with separate activity and restorative care departments. Here, kinesiologists are hired to perform all of the restorative care duties. In this role, they are responsible for assessing residents, creating and implementing individualized exercise plans and programs meant to restore function.

Kinesiologists are also hired by long-term care homes on a consulting basis to teach staff proper lifting and transferring techniques as well as safe and proper use of mechanical lifting and transferring devices as part of minimal lift training.

Hospital

In hospitals, kinesiologists work in the following areas:

1. As health and safety managers or coordinators developing and implementing health and safety initiatives, such as training, education, and policies and procedures for hospital staff. They also conduct physical demands analyses, ergonomic assessments, and create return-to-work programs for staff.

2. As part of the staff of the hospital, they may be responsible for providing exercise programs for hospital staff to help with their overall health, well-being and safety.

3. As members of specialized teams such as neurosurgical and cardiological monitoring teams, they monitor and evaluate the output and data from a measuring source to ensure the patient's safety and well-being. Some examples of this are Electrocardiography (ECG) and Electromyography (EMG).

4. As rehabilitation providers, creating therapeutic exercise programs for post-operative patients and patients with many different types of conditions.

Community Health Care

In community health care, kinesiologists work as rehabilitation providers, exercise physiologists or trainers providing activation and exercise programs to clients with metabolic disorders, orthopaedic problems, and other conditions that would benefit from physical activity. For example, kinesiologists may work with people with diabetes, heart disease, osteoarthritis, cancer or obesity. They may work independently or within a team.

2.3 Education and Training

Thirteen Ontario universities offer kinesiology programs, in which approximately 7,000 students are enrolled. Most of the university kinesiology programs in Canada are accredited by The Canadian Council of University Physical Education and Kinesiology Administrators (CCUPEKA). The accreditation process sets minimum standards and guarantees the basic quality of programs and their ability to deliver both disciplinary knowledge and practical skills. On average, 2,000 graduates enter the field each year.

While university programs vary, students of kinesiology generally must follow a course of study that emphasizes biomechanics, anatomy, physiology and psychomotor behaviour.

- Biomechanics is the science that describes and predicts the conditions of rest or motion on biological systems under the action of forces. Practitioners must be familiar with the scientific principles and laws underlying this field including mechanical analyses, kinematics, and the kinetics of human movement (clinical and sports applications). Students graduate with the knowledge of how to apply biomechanical principles to understand and analyse the causes of human movements and their effects on the body.

- Physiology is the in-depth study of the physiological responses exhibited by human subjects to acute exercise and physical conditioning. The curriculum includes particular emphasis on the study of aerobic and anaerobic metabolism (work, energy, power, metabolic rate) and cardio-respiratory functions (cellular and systems level processes), types and quantities of exercise, influence of varying environmental conditions and the effects of growth, aging, hereditary factors, nutritional status and disease on exercise responses and adaptations facilitating a thorough knowledge of the acute and chronic changes that may occur. Practitioners apply this knowledge to diverse groups that range from the inactive to elite athletes.

- Human anatomy is the in-depth study of all anatomical structures as it relates to the function of the human body, including the cardiovascular, nervous, muscular and skeletal systems.

- Psychomotor behaviour and motor learning incorporate the body of knowledge on human information processing, and the principles of motor learning and control as it relates to normal and abnormal human movement. Motor control studies impart knowledge of the neural pathways of movement and movement sensation. Neural control includes the study of kinesthesia, spinal reflex, neuroanatomy, anatomical considerations, pathways, gait, balance (vestibular), voluntary and involuntary execution and interpretation of movement.

Some interveners raised the concern that the degree of variability among kinesiology educational programs is too wide. Others have cited concerns that kinesiology programs may not prepare practitioners to work with ill, injured or compromised patients because of a lack of emphasis on pathology of illness and disease. Another concern is that not all kinesiology programs offer clinical placement or practicum experience as part of their curricula.

2.4 The Ontario Kinesiology Association (OKA)

The Ontario Kinesiology Association has represented the kinesiology profession in Ontario for twenty-three years. In 2003, the Association created two divisions under its umbrella. They are, the Ontario Kinesiology Authority, which regulates the profession on a voluntary basis, and the Ontario Kinesiology Society, which promotes the advancement of the profession.

The Authority awards certification to members meeting a high standard. Certified Kinesiologists (CK) must have a four-year honours science undergraduate degree in kinesiology with core competencies in biomechanics, physiology, human anatomy, and psychomotor behaviour and motor learning and control. Once certified, the Authority ensures that members remain current by requiring participation in its continuing education program. The Authority also requires that members adhere to a professional code of ethics. Finally, it handles complaints brought by members of the public. While it has a high level of compliance, participation in the Authority is voluntary and it does not have the legal power to enforce discipline or quality assurance obligations of its members.

The Society promotes the profession, provides members' services and liaises with other organizations, including government, business, and universities. The Association currently has a mandate from the profession to seek regulation, preferably under the *RHPA*.

3. Factors Informing HPRAC's Recommendation

3.1 Risk of Harm

Submissions received provided a number of examples of risk of harm. For instance, a flawed assessment of an individual's functional capacity may result in the design of an exercise or rehabilitation program that could cause injury, or even death, to the client, or cause the client's recovery to be compromised or delayed.

Similarly, fitness and physical testing, maximal testing of cardiopulmonary function and strength and endurance testing can cause injury or death if the kinesiologist fails to observe indications that the client's limits have been reached.

Matters of indirect harm, such as breaches of confidentiality, were also raised.

Opponents of the application for regulation disputed the risk of harm to clients because they maintain that kinesiologists deal mainly with healthy clients in the fitness and wellness fields where risks are minimal. They claimed that, even in those instances where kinesiologists work with ill patients, they do so in multidisciplinary teams and under the supervision of regulated professionals, thereby reducing the direct risk of harm.

However, given the number of kinesiologists in private practice, and the expansion of the profession into the treatment of more complex cases, HPRAC is convinced that there is adequate evidence of significant risk of harm in the practice of the profession to warrant regulation of kinesiologists.

3.2 Supervision

In cases where the kinesiologist works as an independent contractor, there is often little supervision, and, therefore minimal if any oversight on the skills of the practitioner or on the standard of care provided. This is less of an issue for those employed by health care providers (hospitals, long-term care homes and rehabilitation clinics), where kinesiologists may work as part of a team, and be supervised by other regulated professionals.

However, the majority of the OKA's membership is in independent practice where there is no supervision of their performance. This significant lack of supervision strengthens the case for regulation.

3.3 Willingness of Practitioners to be Regulated

Subsequent to the Minister's referral, the OKA submitted a formal application for regulation in response to a lengthy questionnaire from HPRAC. The OKA proposes the regulation of kinesiology as a distinct health profession under the *RHPA*, with its own profession-specific Act, separate from any currently regulated health profession.

In making its submission, it attests that its membership
- is in favour of statutory regulation,
- accepts the costs of regulation, and
- supports recognition of the OKA as the senior association representing the profession.

The profession has consistently spoken with one voice and is willing to accept the conditions of regulation.

3.4 Public Interest

The division of the OKA into two authorities, one dealing with regulation, and one with advocacy, indicates a readiness to be regulated and a strong commitment to the public interest. Due to this division, members of the Association are familiar with most of the requirements of professional self-regulation, including a complaints and discipline process, guidelines for practice standards, continuing education requirements, and the costs associated with self-regulation.

The OKA demonstrates an understanding of the primacy of protecting the public interest in its assertion that regulation would improve the quality of care and continuing competence of kinesiologists, protect the public and employers of kinesiologists from unqualified practitioners, clarify the role of a regulatory college as the only body qualified to register members, provide more choice in the availability of health care providers, and provide the public with recourse in the event of harm caused by a kinesiologist.

3.5 Capacity-Building

Demographic trends show that the demand for kinesiologists to provide ergonomic assessments will increase as more people enter fields providing daily care to seniors and the elderly. Similarly, the aging population will result in an increased demand for functional assessment specialists and exercise therapists. As kinesiologists increase their involvement with care for those with more chronic conditions, demand for their services is expected to rise. Regulation of kinesiologists is one means to encourage entry into the profession, and to build the capacity and competence of those in the practice.

3.6 Workplace Safety

In 2005 the Ministry of Labour launched a multi-year initiative, the Pains and Strains Campaign, to reduce ergonomic-related injuries (chiefly musculoskeletal disorders) in the workplace. Recently, the ministry's Ergonomics Advisory Panel tabled a report recommending measures to reduce musculoskeletal injuries. One of its main recommendations is to increase the number of trained ergonomists. The ripple effect of the Ministry of Labour's initiative will be to engage more kinesiologists to conduct ergonomic assessments, and to contribute to health promotion and injury prevention initiatives.

The application of ergonomics in the workplace is important not only in manufacturing and industrial establishments, construction and mining, but also in health care fields (such as long-term care homes) where workers often perform repetitive, forceful or awkward movements on bones, joints, ligaments and other soft tissues, frequently leading to lost-time injuries that impact workplace safety and insurance costs.

There is notable confidence in the contribution of kinesiologists to health and safety.

3.7 Health Promotion and Prevention

Once mainly associated with athletics, kinesiologists have taken on significant roles both in health promotion among the workforce and the general public, and in the delivery of health care services to patients, clients and at-risk groups. As Ontarians shift their focus from illness to wellness, there is an opportunity to include kinesiologists as a profession making significant contributions to health and wellness.

3.8 Consumers

HPRAC was unable to conduct a broad public opinion survey on the regulation of kinesiologists and cannot provide strong evidence of complaints from consumers regarding kinesiologists, nor does the Advisory Council have evidence of strong public demand for regulation. It may be that consumers are unaware of occasions when they have received care from a kinesiologist. HPRAC, however, does see kinesiology as a growing health care practice that is moving to serve more complex cases. As such, regulation would protect the public, and make kinesiologists more accountable to patients and clients.

This is also true with respect to matters of indirect harm. For instance, breaches of confidentiality or economic exploitation where kinesiologists in private practice charge consumers on a fee-for-service basis may be grounds for professional misconduct in a regulatory environment. Professional standards of practice would protect consumers from fraudulent billing or the provision of unnecessary services, and provide recourse through a complaints process if they occur.

4. Summarizing the Case for Regulation

HPRAC's central recommendation is that kinesiology should be regulated in Ontario under the *Regulated Health Professions Act (RHPA)*. The Advisory Council reached this conclusion after:

- investigating the increasingly important work of kinesiologists as primary care providers in prevention, treatment and rehabilitation of musculoskeletal conditions; and
- considering the valuable insights of numerous stakeholders.

HPRAC agrees that significant risks exist where untrained or unqualified practitioners are in private practice or engaged in treating vulnerable groups in hospital, long-term care and community settings. Regulations under the *RHPA* have many public interest benefits from specifying professional qualifications and proficiencies to setting conduct and practice standards.

HPRAC notes, in particular, that the OKA has worked for many years to enhance the professional activities of its association through a separate division of the association that responds to public interest matters, rather than the particular interest of, and advocacy for, the kinesiology profession. The Advisory Council notes this as evidence of the willingness of kinesiologists to be regulated, and the commitment of the profession to the public interest.

5. Options for Regulation

5.1 Creating a New College for Kinesiology

As there is a history of positive experience with the regulation of two related professions under the *RHPA*, HPRAC considered whether it would be advisable to regulate kinesiology as a related profession with one of the health professions currently regulated under the *RHPA*, including physiotherapy or chiropractic.

For this to be a workable solution there must be an evident relationship between the two professions, to ensure that standards of practice, qualifications for entry to practice, and continuing education are compatible and collaborative.

While some members of the College of Chiropractors of Ontario also practice some aspects of kinesiology, the scopes of practice are not the same. There are two significant differences: chiropractors are qualified to diagnose conditions and are trained to use adjustment or manipulation in the course of treatment; kinesiologists do not diagnose but are qualified to assess movement, and they do not make use of adjustment or manipulation in the course of prevention or treatment.

There are also differences in the scopes of practice for physiotherapists and kinesiologists. Physiotherapists are authorized to perform two controlled acts: 1) moving the joints of the spine beyond a person's usual physiological range of motion using a fast, low amplitude thrust; and 2) tracheal suctioning. Neither of these acts is included in the practice of kinesiology, or in the training for kinesiology practice. Additionally, few kinesiologists employ various forms of electrophysical agents (such as cryotherapy, heat therapy and electrotherapy) that are included in physiotherapy therapeutic modalities; those who use electrotherapeutic modalities require post-graduate training to reach competency standards.

As a result of the significant difference in treatment modalities, HPRAC concludes that the best mechanism for the regulation of kinesiology under the *RHPA* would be as a distinct college to be called the College of Kinesiologists of Ontario, with the obligation to develop, implement and enforce qualifications, practice standards, and quality assurance programs specific to the practice of kinesiology.

5.2 Scope of Practice

HPRAC recommends that the scope of practice for kinesiology should be:

> the application of scientifically based principles to enhance the strength, endurance and mobility of individuals with or without functional limitations, and the administration of musculoskeletal, neurological, biomechanical, physiological, psychological and task-specific tests, assessments, and measures.

5.3 Title Protection

HPRAC recommends that the title "kinesiologist" should be restricted to members of the College.

5.4 Controlled Acts

In its submission to HPRAC, the OKA explained that kinesiologists do not diagnose; rather, they provide clinical impressions based on the objective data they obtain regarding function and its relative application to activity. Kinesiologists use diagnostic equipment and tools, such as heart rate monitors, oxygen output and input concentration devices, electrocardiograms, oscillometers and vibration meters, and blood pressure measurement tools amongst others, to obtain data and information regarding human performance.

HPRAC supports the OKA's recommendation that no controlled acts need to be authorized for the profession.

5.5 Council Composition

A comparative analysis of professions with membership of comparable size led to HPRAC's recommendation that the Council of the College of Kinesiologists be composed of at least seven and no more than nine persons who are members elected in accordance with the by-laws of the College; at least five and no more than seven persons appointed by the Lieutenant Governor in Council, and one person selected in accordance with the by-laws who is a member of the faculty of a kinesiology program of a university in Ontario.

6. Transition to Regulation

In the course of its review, HPRAC noted a number of items to be addressed during the transition-to-regulation. Accordingly, the Advisory Council recommends establishing a Transition Council to undertake some specific tasks.

6.1 Transitional Council

Before a College of Kinesiologists is fully functional, a Transitional Council would take the appropriate steps to bring educational programs to consistent standards, establish entry-to-practice qualifications and implement examinations. Another responsibility of the Transitional Council would be to introduce rigourous quality assurance processes resulting in better care for clients.

Specific tasks include the following:

1. Compiling a register of persons who now practice as kinesiologists, including the following information:
    i. Generic demographic information including name, date of birth business address, telephone, fax, email address;

  ii. Qualifications and competencies;
  iii. Education and training;
  iv. Nature of practice.

2. Establishing criteria for a baccalaureate program in kinesiology in Ontario, including core competencies, clinical experience, and a qualifying examination. In particular, educational programs for kinesiology students who seek to work in health care and who seek to deliver and direct patient care must include expanded clinical training and clinical placement opportunities.

3. Establishing criteria for the registration of kinesiologists in Ontario, including:
   i. A pre-registration prior learning assessment program for persons currently practicing kinesiology;
   ii. A pre-registration qualifying and educational bridging program for persons currently practicing as kinesiologists;
   iii. Undertaking an initial registration process for persons who qualify for registration.

4. Developing standards of practice for each area of practice.

5. Establishing standards for mandatory consultation, referral and transfer of care.

6. Establishing a complaints and discipline process.

7. Establishing processes for the election of the Council.

8. Overseeing the election of the Council.

These responsibilities can be delineated for the Transitional Council in an Order-in-Council that appoints the Council.

6.2 Transitional Council Membership

HPRAC considered the appropriate composition of the Transitional Council, and recommends that it be comprised of five to seven professional members and three to five members of the public.

The professional members should include representatives nominated by the Ontario Kinesiology Association and the Canadian Society for Exercise Physiology. This balance will assist in ensuring that the public interest is represented, along with the particular professional knowledge that will contribute to the development of practice standards and definition of qualifications. The Transitional Council should have the power to appoint a Registrar so that the registration activities can proceed directly. HPRAC estimates that the work of the Transitional Council can be completed within a two-year timeframe, after which the Council will be appropriately constituted. The Transitional Council could establish subcommittees to provide advice and consideration on matters leading to the establishment of the College and its Council.

7. Recommendations

HPRAC recommends to the Minister:

1. That kinesiologists be regulated under the *Regulated Health Professions Act, 1991*.

2. That a College of Kinesiologists of Ontario (Ordre des kinésiologues) be established.

3. That the scope of practice for kinesiology be defined as follows:
   the application of scientifically based principles to enhance the strength, endurance and mobility of individuals with or without functional limitations, and the administration of musculoskeletal, neurological, biomechanical, physiological, psychological and task-specific tests, assessments, and measures.

4. That the Council of the College of Kinesiologists be composed of at least seven and no more than nine persons who are members elected in accordance with the by-laws of the College; at least five and no more than seven persons appointed by the Lieutenant Governor in Council, and one person selected in accordance with the by-laws who is a member of the faculty of a kinesiology program of a university in Ontario.

5. That the council has a president and vice-president elected annually by council from among its members.

6. That every member who practices and resides in Ontario and who is not in default of payment of the annual membership fee be entitled to vote in an election of members of the Council.

7. That the use of the title "kinesiologist" be restricted to members of the College.

8. That a person who is not a member of the College may not hold him or herself out as a kinesiologist.

9. That the Lieutenant Governor in Council, on recommendation of the Minister, appoint, for a two-year duration, a Transitional Council and Chair.

10. That the Transitional Council be composed of at least five and no more than seven persons who are representatives of the Ontario Kinesiology Association and the Canadian Society for Exercise Physiology, and at least three and no more than five persons who are not members of these Associations or of a regulated College under the *RHPA*.

11. That the Transitional Council and its employees and committees have the authority to do anything that is necessary or advisable until the College Council is established.

12. That the Transitional Council have the authority to appoint a Registrar, and the Registrar and the Council's committees have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

13. That the Minister direct the Transitional Council to undertake certain functions, including but not limited to:

    i. Inquiring into and determining the qualifications and competencies, including the education and training, of persons holding themselves out as kinesiologists in Ontario;

    ii. Inquiring into and determining the nature of the practice engaged in by persons holding themselves out as kinesiologists in Ontario;

    iii. Identifying, specifying, and assigning a name to areas of practice, within the collective practice engaged in by persons holding themselves out as kinesiologists in Ontario;

    iv. Establishing criteria for a baccalaureate program in kinesiology in Ontario, including core competencies, and any qualifying examination;

    v. Establishing criteria for the registration of kinesiologists in Ontario;

    vi. Establishing a pre-registration prior learning assessment program for persons holding themselves out as kinesiologists;

    vii. Establishing a pre-registration qualifying and educational bridging program for persons holding themselves out as kinesiologists;

    viii. Developing standards of practice for each area of practice;

    ix. Establishing standards for mandatory consultation, referral and transfer of care;

    x. Establishing processes for the election of the Council and overseeing the election of the first Council.

REGULATION OF PSYCHOTHERAPY

The Minister's Question

In February 2005, the Health Professions Regulatory Advisory Council (HPRAC) received a referral[1] from Hon. George Smitherman, Minister of Health and Long-Term Care, in which he sought advice from HPRAC on:

> whether psychotherapy should be an additional controlled act under the *Regulated Health Professions Act, 1991, (RHPA)* and if so, which regulated professions should have psychotherapy in their scopes of practice and how standards should be set and measured; and
>
> whether psychotherapists should be regulated under the *RHPA* as a profession, what their scope of practice should be and what controlled acts they should be authorized to perform, as well as any protected titles, and whether it is appropriate that psychotherapists be regulated under an existing profession-specific act.

HPRAC's Response

HPRAC's central response is that psychotherapists and psychotherapy should be regulated in Ontario under the *Regulated Health Professions Act (RHPA)* with a new profession-specific statute, the Psychotherapy Act, that would include an enforceable scope of practice and title protection; and those existing health regulatory colleges whose members practice psychotherapy should develop comparable standards of practice for their members.

1. History of the Referral

The Minister's referral is not the first time psychotherapy has come under consideration. In 2001, HPRAC raised the issue in its report, *Adjusting the Balance: A Review of the Regulated Health Professions Act*, noting that several stakeholders had recommended that psychotherapists be regulated and that psychotherapy be made a controlled act under the *RHPA*.

At that time, the Advisory Council concluded that "regulation of psychotherapists and/or making psychotherapy a controlled act should be reviewed with reference to the nature and extent of associated risk of emotional harm…[and that] the Minister invite a request for a referral from appropriate psychotherapy groups on amending the *RHPA* to list the additional controlled act of psychotherapy." The Minister, in the interest of time, chose to refer the matter to HPRAC directly without a request from a sponsoring organization.

---

[1] Minister's Referral Letter, February 2005, Appendix A

2. The Consultation Process

In response to the Minister's referral, HPRAC embarked on a multi-stage consultation process to seek the views of interested individuals and organizations and examine issues related to possible regulation of psychotherapy. In the course of its review, the Advisory Council prepared and distributed background documents, including a jurisdictional review, a review of case law findings, and a detailed questionnaire. It conducted two-day workshops with representatives of 20 stakeholder groups to discuss matters relevant to the questions posed by the Minister, and to assist in the development of a discussion paper. Subsequently, the discussion paper was widely circulated, and HPRAC hosted eight public consultations in seven cities across Ontario. By November 2005, HPRAC had heard 66 presentations from a broad range of interested parties, and received more than 100 written submissions, all of which were analyzed and considered in the formulation of recommendations. These activities were supplemented by numerous interviews to provide additional clarity on specific issues, along with literature, jurisdictional and case law reviews.

3. Background

3.1 The Current Situation in Ontario

Under Ontario's present regulatory framework, anyone may represent him or herself as a psychotherapist, or use the title "psychotherapist" regardless of credentials, training, education, experience or lack thereof. Similarly, as psychotherapy is not a Controlled Act, psychotherapy may be provided by anyone in Ontario, regardless of their education, training or experience.

While members of currently regulated professions who provide psychotherapy are subject to regulatory action for failure to adhere to appropriate standards in their treatment of patients or clients, there are few standards or qualifications for members of these regulated professions specific to the practice of psychotherapy.

Individuals providing psychotherapeutic services in Ontario can be grouped into five categories:

1. Regulated professionals (psychologists, social workers, physicians, psychiatrists, and nurses, etc.);

2. Trained and qualified practitioners voluntarily affiliated with non-statutory professional associations exercising self-regulatory functions;

3. Trained and qualified practitioners not affiliated with any professional body;

4. Untrained practitioners without credentials who are not affiliated with any professional body; and

5. Those who provide psychotherapeutic services but are exempt or excepted from regulation under sections 29, 30 and 35 of the *RHPA* (Counsellors, Spiritual Counsellors, Aboriginal Healers).

3.2 What is Psychotherapy?

For more than a century, psychotherapy has been a central treatment approach for many individuals suffering from mental health problems, and an important component of Ontario's system of mental health services. The publication, *Standards and Guidelines for the Psychotherapies*,[2] summarizes the four basic psychotherapeutic orientations: psychodynamic, cognitive/behavioural, strategic/systems, and experiential. Within each are various modalities that a practitioner may utilize in patient care.

Forms of Psychotherapy[3]

	Individual	Group	Family
Psychodynamic	• Psychoanalysis • Focal therapy • Psychodynamic psychotherapy	• Insight-oriented heterogeneous group therapy	• Insight-oriented marital/family therapy
Cognitive/ Behavioural	• Cognitive treatment of depression • Rational-emotive therapy	• Group treatment of agoraphobia, • Assertiveness training groups	• Behavioural marital/family treatment
Strategic/Systems	'Uncommon therapy'	• Most heterogeneous group therapies	• Structural family therapy • Strategic family therapy • Paradoxical family therapy
Experiential	• Client-centered therapy • Existential therapy	• Gestalt • Psychodrama • Most homogeneous group therapies	• Experiential family therapy

Psychotherapy is most often characterized by an intense client-therapist relationship which often involves the examination of deeply emotional experiences, destructive behaviour patterns and serious mental health issues.

The practice of psychotherapy is distinct from both counselling, where the focus is on the provision of information, advice-giving, encouragement and instruction, and spiritual counselling, which is counselling related to religious or faith-based beliefs.

---

[2] *Standards and Guidelines for the Psychotherapies*, Cameron, P., Ennis, J. & Deadman, J., Eds., University of Toronto Press, 1998

[3] Clarkin, J.F., Frances, A.J. & Perry, S.W. (1995). The Psychosocial Treatments. In R. Michels (Chairman, Editorial Board) *Psychiatry*. Philadelphia: Lippincott

3.3 How People Receive Psychotherapy Services

At different times in their lives, Ontarians may receive psychotherapy services in a health care facility, such as a hospital, clinic or mental health centre, or by engaging in individual, family or group therapy provided by a practitioner in an office, home or residential setting.

It is estimated that more than 4000 psychotherapists practice in Ontario today.[4] Some are from traditional, regulated health professionals such as psychologists and psychiatrists. Others have graduate-level university education or specialized training in particular therapeutic approaches.

The cost of treating mental health problems in Ontario is estimated to be more than $2 billion annually.[5]

3.4 Regulatory Safeguards

There are four inter-related policy objectives within the *RHPA* that are central to the question of regulation: public protection, quality of care, access and accountability. They are achieved through mechanisms built into the Act. Psychotherapy is practiced in Ontario without benefit of statutory regulation. This means that anyone with or without qualifications may call him or herself a psychotherapist and practice psychotherapy.

Under today's *RHPA*, there are no controlled acts that are specifically authorized to psychotherapists in Ontario, and only physical harm to a patient or client is recognized in the statute. While formal accountability for regulated professionals, including social workers, exists, there is no requirement for unregulated professionals to adhere to standards for education and qualification, continuing competence, complaints and disciplinary processes and practice standards. Further, regulated professionals may practice psychotherapy without educational requirements or standards specific to psychotherapy.

3.5 Education and Training

At present, professional psychotherapy training is diverse with little or no harmonization or standardization. This may be due to the presence of many schools of thought within the broad spectrum of psychotherapy as well as the various professional backgrounds of the practitioners. Unlike social work and psychology, for example, there are no schools of psychotherapy affiliated with any university. Rather, there is a broad range of educational settings for psychotherapy training from academic institutions, such as community colleges, to stand-alone training centres or institutes.

Psychotherapy education is also often structured according to whether it is taught as a single component of a broader, professional skill-set (e.g.

---

[4] These numbers may include some counsellors and individuals providing "therapy" of an indeterminate theoretical basis.

[5] *Selected Costs, Mental Disorders, All Ages, Both Sexes, Ontario 1998*, Public Health Agency of Canada, Economic Burden of Illness On-line. The figure cited does not include costs associated with non-physician providers.

social worker, psychiatrist) or whether it comprises the sole professional foundation (e.g. psychotherapist, psychoanalyst). In the former, competence in psychotherapy is acquired as part of completing general degree requirements, whereas in the latter, training is specialized in psychotherapy alone.

Training for self-identified psychotherapists is varied. Doctoral and master's level psychologists must meet experience requirements working with clients under supervision. Social workers and nurses may have advanced mental health training, including supervised practice experience. For psychiatrists, case supervision is provided during residency training. Other physicians who practice psychotherapy (commonly referred to as "GP psychotherapy") may have little or no formal education in psychotherapy as part of their medical training.

Those outside the currently regulated professions who practice psychotherapy may have completed many years of psychotherapy education and supervised practice – or none at all. Some have completed undergraduate or master's degrees in fields related or unrelated to their careers as psychotherapists. Others have completed programs offered by centres specializing in psychotherapy training, such as the Adler Professional Schools, the Centre for Training in Psychotherapy, the Gestalt Institute, the Ontario Association of Jungian Analysts, and the Toronto Institute for Psychoanalysis. Still other practitioners have received training in Europe or the United States where educational programs in psychotherapy are more numerous. Some have enrolled in programs for which the main entrance qualification is "life experience."

Elements common to all types of formal psychotherapy training include the ability to: listen to and understand clients and patients and attend to nonverbal communication, develop and maintain a therapeutic alliance with patients and clients, understand the impact of the therapist's own feelings and behaviour so they do not interfere with treatment, and recognize and maintain appropriate therapeutic boundaries.

3.6 Current Regulation

Several regulatory colleges include members who provide psychotherapy services. These are the College of Psychologists of Ontario (CPO), the College of Physicians and Surgeons of Ontario (CPSO), the Ontario College of Social Workers and Social Service Workers (OCSWSSW), and the College of Nurses of Ontario (CNO). Practitioners associated with these colleges must meet the qualifications and standards established by their Colleges. CPO, CPSO and CNO are governed by the *RHPA*; OCSWSSW is governed by the *Social Workers and Social Service Workers Act, 1998.*

Psychotherapy services are also provided by persons outside the currently regulated professions. Among this group, some are members of voluntary, self-regulatory professional associations such as the Ontario Society of Psychotherapists, and the Ontario Association of Consultants, Counsellors, Psychometrists and Psychotherapists. These organizations establish education and experience qualifications and practice guidelines for members.

Generally, these include completion of a didactic learning program plus a specified number of hours of supervised practice experience.

Other practitioners have no professional affiliations and adhere to no identifiable standards or codes of ethics.

3.7 Other Jurisdictions

In Canada, Alberta recently restricted the "provision of a psycho-social intervention in cases of substantial thought, mood, perception, orientation or memory disorder that grossly impairs judgement" to six regulated health professions. British Columbia has been reviewing the possible regulation of psychotherapy/clinical counselling as a subset of counselling for several years. While Quebec has formally regulated a number of professions, including but not limited to psychologists, psychoeducators and social workers, the regulation of psychotherapy remains under consideration.

In the United States many states restrict the practice of psychotherapy through a range of approaches – from voluntary registration with a state board to formal licensing.

The United Kingdom is considering mandatory registration for psychotherapists. The UK currently has a voluntary system of self-regulation that brings together 80 voluntary professional associations under the umbrella of the United Kingdom Council for Psychotherapy.

In the spring of 2005, the New Zealand National Psychotherapy Association formally requested that psychotherapy become a regulated profession. Australia is also in the midst of a professional review regarding the regulation of psychotherapists.

4. Factors Informing HPRAC's Recommendation

4.1 Risk of Harm

Given that the practice of psychotherapy often takes place in private, unsupervised settings with emotionally vulnerable patients/clients, it is widely agreed that there is a significant risk of harm inherent in the practice of psychotherapy.

While consequences of substandard or negligent practice may not always be obvious, survey data, professional disciplinary cases and court actions, together with the views of regulators and practitioners in the field based on experience, reveal that incidents of abusive and negligent behaviour with serious consequences for patients or clients, and sometimes third parties, occur in the context of psychotherapy. The risk of harm is one of the main justifications cited by other jurisdictions for regulating the practice of psychotherapy.

There are two major sources of potential harm for patients/clients receiving psychotherapy:

- the nature of the relationship between patient/client and therapist; and

- the failure to properly assess or implement specific psychotherapeutic interventions.

Examples of harm arising from the therapeutic relationship include:

- exploitation and/or abuse of the patient/client;
- engaging in sexual contact or any sexual relationship with the patient/client;
- breaching the patient's/client's privacy/confidentiality through unsanctioned disclosure of clinical information

Examples of harm arising from failure to properly assess or implement care include:

- employing inappropriate treatment approaches, thereby causing delay in appropriate management or resolution of the problem, and possible exacerbation of the patient's/client's condition; and
- failure to identify physical or mental health issues requiring other forms of treatment.

The nature of psychotherapy practice, particularly the intense client-therapist relationship, brings with it special concerns, for example transference (the redirection of feelings and desires to a new object, sometimes the psychotherapist). In addition, an inherent power imbalance exists in the patient-therapist relationship, one that may be manipulated and exploited by an unscrupulous practitioner dealing with an emotionally fragile or vulnerable client.

Throughout HPRAC's consultation process, a large majority of stakeholders clearly stated that there is risk of harm associated with the practice of psychotherapy. This conclusion was confirmed by jurisdictional reviews. In particular, two groups were identified as posing an increased risk of harm to patients or clients:

- Unregulated practitioners engaged in private individual practices, especially those without professional affiliation, supervision, or a circle of peers; and
- Regulated professionals who practice psychotherapy without formal training in psychotherapy.

4.2 Supervision

A significant number of psychotherapists practice independently, often from their own homes, without supervision, institutional constraints or opportunity for peer collaboration or oversight. Many have no affiliation with professional groups or mentors. The number of solo practices appears to be increasing, as fewer institutions and mental health agencies offer psychotherapy.

4.3 Standards of Practice

At present, there are few, if any, consistent professional standards specific to psychotherapy in place for psychotherapists who are members of regulated colleges, and a patchwork of standards for unregulated practitioners who may or may not adhere to voluntary standards of practice. Health professionals who have been stricken from professional registers and subsequently taken up psychotherapy practice are not accountable to standards of either a professional or voluntary body.

4.4 Consumers

There is a great deal of public confusion about the roles and qualifications of practitioners – psychiatrists, psychologists, psychotherapists and other disciplines – offering psychotherapy. Many people are surprised to learn that psychotherapy is not regulated. They assume psychotherapists are more or less equally qualified. Lack of public awareness exacerbates the risk of harm. In this context, it should be noted that the province's Psychiatric Patient Advocate Office strongly supports regulation of psychotherapy.

4.5 Accountability

The lack of a complaints body or process for unregulated psychotherapists, other than the courts, is seen as a serious public policy shortcoming. It leaves clients or patients at risk and without recourse, except at considerable expense and unwanted public exposure. Many other jurisdictions, including at least a dozen U.S. states, have concluded for this reason that psychotherapy carries a significant risk of harm that warrants some form of regulation.

4.6 Willingness to be Regulated

HPRAC's consultations with stakeholders showed strong support for regulation.[6] Support for regulation is found across a wide range of groups representing both currently regulated and currently unregulated practitioners. Of particular note is the strong support shown by the Ontario Coalition of Mental Health Professionals, representing 4,300 practitioners.[7] Additionally, a large number of practitioners belong to voluntary organizations where a condition of membership is compliance with practice standards, discipline and codes of ethics. This further indicates a willingness to accept the responsibilities of self-regulation.

4.7 Ability to Favour the Public Interest

Two factors demonstrate the commitment of the psychotherapist community to the public interest. One is the existence of a number of voluntary, self-regulating organizations that have established membership qualifications. These bodies have codes of ethics and professional conduct and complaints committees and continuing professional development programs that support the public interest principle. Members pay fees to support their organization's operations.

While membership in one of these professional associations or institutes confers professional recognition and stature on its members, there appears to be a genuine desire on the part of professional organizations to enhance practice standards and professional accountability. In addition, the number of practitioners represented by organizations seeking regulation suggests that the leadership has the support of a sizeable membership base.

---

[6] Close to two-thirds of stakeholders who made written submissions or oral presentations to HPRAC supported regulation.

[7] The Ontario Coalition of Mental Health Professionals includes 10 professional organizations and six affiliated training institutes.

The second factor is that regulated colleges, with a number of psychotherapist practitioners, have a duty to favour the public interest over the interest of the profession, and their allegiance to this principle was clear to HPRAC throughout the discussions.

4.8 Access to Service

There is general recognition that psychotherapists provide important mental health services. In some parts of the province, independent psychotherapy services are more readily accessible than mental health services provided in institutional and community mental health settings. HPRAC heard that some employers feared that current mental health workers may not be able to provide some mental health services if a broad definition of scope of practice is employed. Others noted the impact that regulation might have on special populations[8], cultural minorities and under-serviced areas, especially remote and rural communities.[9]

The majority of respondents told HPRAC that to protect the public interest it would be important to expand regulation of qualified psychotherapists beyond those practitioners who are currently regulated to ensure that the services and skills they provide are not lost to the mental health system.

> Admission to practice should not be unduly restricted by unnecessarily onerous or narrow training criteria...admission to the profession should not be limited to currently recognized regulated health professionals, as this would unduly limit public access to well-qualified practitioners with other backgrounds.
>
> College of Physicians and Surgeons of Ontario

It should be noted that the majority of respondents said that regulation should protect the public interest by supporting continued access to psychotherapy services while requiring appropriate high minimum qualifications, standards of practice and public accountability for practitioners.

4.9 Regulating the Practice or the Professional

The Minister asked HPRAC for advice on whether psychotherapy or psychotherapists should be regulated. Differences between the two approaches – regulating the activity versus regulating the professionals who provide the activity, and their implications, are not easily grasped, particularly by those unfamiliar with regulatory concepts. Were psychotherapy to be designated a controlled act, the activity of psychotherapy would be regulated, and authorization to perform the act would be given to a limited number to practitioners with appropriate qualifications. Were psychotherapists to be regulated, their scope of practice relating to psychotherapy would be defined in the statute, and they would be limited to acting within the scope. This question was made more complex by the fact that the psychotherapist cohort is made up of both regulated professionals and unregulated practitioners. For the latter, neither controlled act nor scope of practice provisions would apply.

---

[8] "...the types of services that our counsellors provide...are based on cultural and traditional values...Regulating psychotherapy and counselling would be detrimental to our clientele as they would be underserviced." Ontario Native Education Counselling Association.

[9] "Highly restrictive regulation would virtually eliminate counselling and psychotherapeutic service in rural communities in Ontario." Family Services London/Thames Valley

5. Summarizing the Case for Regulation

Based on analysis of the risk of harm to the public posed by the unregulated practice of psychotherapy, developments in other jurisdictions, and thoughtful opinion and experiences of professionals, practitioners and members of the public, HPRAC has concluded that regulation is in the public interest. Regulation will reduce the risk of harm in the practice of psychotherapy in the following ways:

- **Entry-to-practice** – Introduction of high minimum educational and supervised practice requirements for entry-to-practice will provide assurance that those who are registered as psychotherapists have the foundational skills and are qualified to provide psychotherapeutic services.

- **Quality Assurance** – Participation in professional quality improvement, professional development and continuing competence activities will provide opportunity for peer collaboration, case review and institutional or collegial oversight.

- **Improved Accountability** – Clients or patients of currently unregulated practitioners will gain new recourse for incidents of alleged incompetence, professional misconduct, sexual abuse or other boundary violations through complaints and discipline processes of a regulatory body.

- **Enforcement** – Statutory regulation will establish complaints, discipline and quality assurance programs. With professional regulation comes accountability, ultimately through a system of penalties, including loss of registration.

6. HPRAC's Initial Conclusions

After extensive examination and analysis of the salient issues, HPRAC reached the following conclusions:

1. Both psychotherapy and psychotherapists should be regulated.

2. Psychotherapy can be distinguished from supportive counselling. Counselling that is the provision of information, encouragement, advice and instruction about emotional, social, educational or spiritual matters is not psychotherapy.

3. Any new regulatory framework should address both currently regulated and currently unregulated practitioners.

7. Regulatory Options Considered

Having concluded that psychotherapists and psychotherapy should be regulated in Ontario, HPRAC considered a number of regulatory options.

7.1 Voluntary Self-Regulation

Because of the risk of harm associated with the practice of psychotherapy, and the overwhelming consensus by a broad spectrum of stakeholders that statutory regulation is needed, the status quo, including voluntary self-regulation, was not seen as a viable option. Voluntary self-regulation, while useful, lacks powers of enforcement.

7.2 Registry of Practitioners

Another option considered is a registry of psychotherapists in Ontario. Initially, practitioners would be encouraged to join the registry on a voluntary basis and provide information about their practice areas, training and qualifications. This would be accessible to the public and could raise public awareness. While a registry would provide a limited form of public protection, it would not filter out unqualified practitioners, set standards or provide a complaints and discipline process. As is now the case, anyone with or without qualifications would be able to practice psychotherapy, call him or herself a psychotherapist and be included in the registry. Ultimately, this was rejected as a stand-alone option because it would not provide sufficient public protection.

7.3 Title Protection

Title protection, by itself, is the weakest form of regulation on the continuum of regulatory options. Under the *RHPA*, title protection provides a measure of public protection by identifying providers who have met qualifications for registration in the College concerned. It does not, however, stop others from engaging in activities normally performed by those entitled to use the title. It only prevents others from using the protected title(s). For this reason, HPRAC did not consider title protection, on its own, as providing adequate public protection.

7.4 Regulation within an existing College

HPRAC considered whether it would be possible to add practitioners to existing Colleges. Under this option, currently unregulated practitioners wishing to designate themselves as psychotherapists would be required to join an existing College. Some in this category may have credentials that would qualify them for registration with an existing College. For others lacking such qualifications, a new class of registrant would have to be created within one or more existing Colleges.

The greatest obstacle to this option is extremely limited support from both regulated and unregulated practitioners. Furthermore, no College appeared willing to take on this added regulatory burden. This option, too, was rejected.

7.5 Controlled Act

HPRAC considered defining a controlled act of psychotherapy and limiting its practice to those authorized to perform it under the *RHPA*, either as members of an existing *RHPA* College or of a new College.

A controlled act of psychotherapy would provide the highest level of regulation and public protection. The disadvantage is that it would require a precise definition of the act of psychotherapy comparable to the wording of the 13 existing controlled acts under the statute. This is not viable, because psychotherapy is a process and cannot be characterized as a single act.

The controlled act approach would also bring with it the requirement for significant change to the *Social Workers and Social Service Workers Act, 1998*, including the addition of a new regulatory principle for the social work profession. A number of social workers practice psychotherapy. If changes to the Act were not made, social worker-psychotherapists would be required to qualify for dual membership in either an existing or new *RHPA* College in addition to their own professional College.

Concerns were expressed to HPRAC that a controlled act of psychotherapy would stifle the evolution of a dynamic and maturing discipline. HPRAC concluded that adding an additional controlled act of psychotherapy in the *RHPA* was not a workable option.

7.6 Amending the *RHPA* Harm Clause

The *RHPA* harm clause (Section 30) prohibits individuals, other than regulated health professionals acting within their scope of practice, from treating or advising someone about their health in circumstances where it is reasonably foreseeable that serious physical harm may result. The effect of the harm clause is to prohibit either lay persons or professionals acting outside their scope of practice from performing potentially harmful activities related to a person's physical health.

An amendment to the *RHPA* harm clause to include psychological or emotional harm could serve to prohibit individuals, other than regulated health professionals acting within their scope of practice, from treating or advising someone about their health in circumstances where it is reasonably foreseeable that serious emotional, psychological or physical harm may result.

HPRAC is of the opinion that mental health should be considered as part of the health of an individual in addition to physical health. This is further discussed in the Legislative Framework report.

8. Preferred Approach to Regulation

HPRAC is convinced that the *RHPA* is the preferable regulatory model, and that psychotherapy should be regulated under the Act through a new College of Psychotherapists.

HPRAC proposes that both the practice of psychotherapy and its practitioners be regulated by way of title protection and an enforceable scope of practice within the *RHPA*.

9. A New Regulatory Framework for Psychotherapy

9.1 Establishing a New College of Psychotherapists

HPRAC has concluded that a new College of Psychotherapists should be established under the *Regulated Health Professions Act, 1991*.

While some respondents argued for a regulatory framework outside the *RHPA*, the reason often cited was the belief that regulation under the *RHPA* would exclude currently unregulated practitioners. HPRAC proposes that practitioners who are currently unregulated would be required to become members of the new College.

Practitioners who are now regulated would continue to be regulated under their own Colleges.

9.2 Composition of the Council of the College

HPRAC recommends that the Council of the College be composed of at least six and no more than nine persons who are members elected according to the College's by-laws and at least five and no more than eight persons appointed by the Lieutenant-Governor-in-Council. The Council would elect a President and Vice-President annually from among its members.

9.3 Cross-Professional Collaboration

To ensure that members of all regulatory colleges who practice psychotherapy have benefit of broad standards that can be applied to the unique circumstances of their professions, HPRAC recommends that the Council of the College of Psychotherapy establish an Advisory Committee to include representatives of the College of Psychologists of Ontario, College of Physicians and Surgeons of Ontario, Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario.

9.4. Members of Existing Colleges

HPRAC has concluded that members of existing *RHPA* Colleges and of the Ontario College of Social Workers and Social Service Workers, who already practice within regulatory frameworks established by the *RHPA* and *Social Work and Social Service Work Act* (1998) respectively, should be able to provide psychotherapy without having to become members of an additional, new regulatory body.

They would, however, be required to demonstrate compliance with qualifications and standards specific to psychotherapy. Since the College of Social Workers and Social Service Workers is outside the *RHPA* framework, (having its own stand-alone Act), a specific provision would be required to include this key group of professionals in the regulatory framework for psychotherapy. Such a provision is recommended.

9.5 Standards in Existing Colleges

In the course of its work, HPRAC heard significant concern that existing Colleges have yet to establish specific educational qualifications and standards to adequately support the safe and effective practice of psychotherapy by their members. HPRAC shares that concern.

HPRAC recommends that the Colleges of regulated professionals who practice psychotherapy (the Colleges of Psychologists, Social Workers and Social Service Workers, Nurses, and Physicians and Surgeons) develop, implement and enforce their own minimum qualifications and standards of practice specific to psychotherapy. If the existing Colleges fail to develop standards specific to psychotherapy, their members who practice psychotherapy would be required to adhere to standards of the College of Psychotherapists.

9.6 Title Protection and Representation

Title protection protects the public interest by providing patients with a clear way to identify whether a practitioner has the minimum educational and other qualifications to practice psychotherapy under the purview of an appropriate regulatory body.

A protected title or titles must be understandable to the public, and there should be a recognized link between the title(s) and the services being provided. While stakeholders support protection of the title "psychotherapist," some expressed concern about limiting title protection to a single title. A number of participants suggested that other titles be included, including "psychotherapist/counsellor", "marriage and family therapies" or "art therapist".

HPRAC is convinced, however, that the title "psychotherapist/counsellor" would lead to confusion regarding the scope of the regulated activity by suggesting that all counselling activities fall within the regulatory framework. Other titles, as appropriate, can be added by regulation.

Under the *RHPA*, title protection is supported by "holding out" restrictions. These restrictions prohibit persons, other than members of a regulatory College, from representing themselves ('holding themselves out') as members of that College, either directly by using the protected title, or indirectly by using words or conduct to suggest they are authorized to identify themselves as such.

The title "psychotherapist" is widely used and accepted by practitioners, other health care professionals, patients, clients and members of the public. For this reason HPRAC recommends that "psychotherapist" be the protected title.

9.7 Enforceable Scope of Practice

HPRAC has concluded that the risk of harm presented by psychotherapy is serious enough to warrant removing it from the public domain and requiring those who perform it – whether they call it psychotherapy or something else – do so within a regulatory framework that establishes and enforces high minimum qualifications and standards.

Currently, the activities regulated by the *RHPA* fall into two general categories and regulatory approaches:

- Acts that present a risk of harm to patients such that they are listed in the *RHPA* as "Controlled Acts". Controlled acts can only be performed by members of specified *RHPA* Colleges who, in order to become members, must meet relevant minimum qualifications and standards.

- Acts that do not present a risk of harm that warrant removing them from the public domain as controlled acts. Performance of these non-controlled acts is not limited to members of *RHPA* Colleges. While members of *RHPA* colleges may perform these acts while acting within the scope of their respective professions, there is no prohibition to prevent others from performing them too (including members of other *RHPA* Colleges and unregulated practitioners).

The problem, however, is that the *RHPA*'s controlled act approach is unworkable for psychotherapy. This is because it is impossible to single out a clearly discernible act that forms part of the practice of psychotherapy (and is unique to it) that serves to create the risk of harm for patients. Rather, it is the process of the practice of psychotherapy (and variable elements within that process) that creates this risk of harm.

HPRAC's recommended solution to this problem is to introduce into the *RHPA* framework the concept of a legally enforceable scope of practice for psychotherapy for all practitioners. The relevant provision would describe the nature and extent of the activities that will be subject to this new regulatory framework regardless of the title or label used by a practitioner, and prohibit practitioners of existing Colleges who are not qualified to practice psychotherapy and those who are not members of the new College of Psychotherapists from practicing within that scope.

Establishing a legally enforceable scope of practice for psychotherapy will protect the public interest in two important ways:

- It will provide better protection against practitioners who may seek to evade the new regulatory framework simply by using a title other than the protected title or titles (i.e. title-dodging). This is an important point given the wide range of titles used by those who currently practice psychotherapy.

- It will help communicate to members of the public the range of activities for which membership in the new College is required to ensure minimum educational and other qualifications for practice.

While this recommended approach adds a new regulatory method to the *RHPA*, it has been followed in other jurisdictions to regulate psychotherapy (including, for example, Arizona, Florida and California). Moreover, this is not an approach that is foreign to the regulation of health professions in Ontario. Legally enforceable scopes of practice were a feature of the former *Health Disciplines Act* (Ontario).

For these reasons, HPRAC recommends an enforceable scope of practice for psychotherapists in Ontario.

9.8 Proposed Scope of Practice

HPRAC proposes the following description of psychotherapy form the scope of practice in the new regulatory framework:

> Psychotherapy is the provision of a psychological intervention or interventions delivered through a therapeutic relationship for the treatment of cognitive, emotional or behavioural disturbances.

This proposed scope takes into account the comments received throughout HPRAC's consultation process.

The scope of practice would apply to a member in good standing of the College, the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who has met the qualifications specific to the practice of psychotherapy as established by their College.

It is to be noted that the initial emphasis of regulation for all practitioners (both currently unregulated and regulated) will be upon the creation of generally applicable qualifications for entry to practice and standards of practice (i.e. requirements that are relevant to all practitioners rather than prescriptive standards specific to each modality within the general field of psychotherapy).

9.9 Exceptions and Exemption – Counselling, Religious Care and Aboriginal Healer

The current *RHPA* contains two exceptions and one exemption pertaining to spiritual and religious care:

- counselling for the purpose of emotional, social, educational or spiritual matters (s. 29(2) of the *RHPA*).
- treating a person by prayer or spiritual means in accordance with the tenets of the religion of the person giving the treatment (ss. 29(1)(c) and 30(5)(c) of the *RHPA*).
- Aboriginal healers providing traditional healing services to aboriginal persons or members of an aboriginal community and aboriginal Midwives are exempt under (s.35 (1)(a)(b) of the *RHPA*).

Given that the proposed new regulatory framework will not encompass counselling, the first exception presents no issue. However, HPRAC recommends that for additional clarity, an exception should be included in the Psychotherapy Act specifying that it "does not apply to counsellors providing information, encouragement, advice or instruction about emotional, social, educational or spiritual matters."

Commentators strongly supported the proposition that faith-based practitioners who provide psychotherapy during the course of spiritual or religious care should meet the same qualifications and standards as other practitioners of psychotherapy. This is a matter that should be reviewed further.

As noted, Aboriginal healers are exempt from the *RHPA*, and HPRAC recommends that there be no change in the exemption for the purposes of the new Act.

9.10 Access to the Controlled Act of Communicating a Diagnosis

The clinical diagnosis of mental or emotional disorders utilizes criteria from the *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSM-IV TR), and is often supported by psychological testing. Currently, a limited number of professionals are permitted under the *RHPA* to diagnose and therefore to "communicate a diagnosis."

It is important to recognize that psychotherapists work from a treatment plan based on three elements: the patient's difficulties or treatment goals; articulation of the obstacles that stand in the way of achieving those goals; and the technique(s) or relationship(s) that can help the patient to learn how to address these obstacles.

Prior to engaging in psychotherapy with a patient, all therapists need to formulate the case and develop an appropriate treatment plan. Assessment plays an important role in the latter. The nature of this assessment may be based on factors that are broader than a Diagnostic and Statistical Manual of the American Psychiatric Association syndrome, or may be based on diagnostic information provided by a physician or psychologist, and then forms the basis of the treatment plan. With respect to the former, the nature of the assessment may be guided by the therapist's professional training and is intended to view the presenting problem through a particular lens or framework. Psychotherapists with a social work background for example, may assess for a link between systemic factors and symptom expression, while those trained in working through the body might assess for a link between areas of physical tension and symptoms. While this may be informative for the practice of psychotherapy, this type of assessment falls short of the threshold for a clinical diagnosis of a mental or emotional disorder.

Because clinical diagnosis is not a key component in the performance of psychotherapy and because training in psychotherapy does not extend to training in clinical diagnosis HPRAC recommends that the controlled act of "Communicating a Diagnosis" is not required for psychotherapy.

10. Transition to Regulation

HPRAC recommends that a Transitional Council be established to oversee a structured transition to regulation of the College of Psychotherapy over a three-year period. The main functions of the Transitional Council would be to:

- Develop a list of practitioners who identify themselves as practicing psychotherapy.
- Identify a core body of knowledge common to all psychotherapy practice, with an emphasis on common foundational elements, and develop educational and experience qualifications and equivalencies for registration.
- Identify education and training programs to enable educational institutions to develop and tailor curricula, as required.
- Enable practitioners to acquire additional training, if required.
- Collaborate with existing Colleges whose members practice psychotherapy with regard to standards.
- Develop registration, complaints and discipline programs and processes.
- Develop communications programs to provide information to regulated and unregulated psychotherapists and members of the public.

10.1 Composition of a Transitional Council

Members of a Transitional Council, its chair and vice-chair would be appointed by the Lieutenant-Governor-in-Council, on the recommendation of the Minister of Health and Long-Term Care. The Transitional Council, in turn, would appoint a Registrar.

In addition to the Chair and Vice-Chair, HPRAC recommends that the Transitional Council be composed of at least six and no more than nine people who are currently unregulated practitioners of psychotherapy; at least five and no more than eight public members; at least four and no more than six representatives (collectively) of the Colleges of Psychologists, Physicians and Surgeons, Social Workers and Social Service Workers, and Nurses.

The purpose of including representatives of the existing Colleges is to ensure their involvement in the development of qualifications and general standards for the practice of psychotherapy. The Colleges have regulatory expertise to contribute to this effort, and would themselves be tasked with similar responsibilities with respect to psychotherapy, and to develop qualifications and standards specific to psychotherapy for their members who practice it.

It is not contemplated that representatives of existing Colleges on the Transitional Council would become members of the governing council of the new College. Their appointments to the Transitional Council would terminate when the new College is officially established. It is anticipated, however, that the existing Colleges would continue to work with the College of Psychotherapists through an Advisory Committee once the permanent council is in place.

10.2 Entry to Practice Requirements

A major task of the Transitional Council would be to establish the foundational qualifications and the educational equivalencies for entry to practice as a psychotherapist, and provide for continuing competence of members.

This would include the identification of common principles from the various approaches to psychotherapy training in Ontario. These principles could then serve as minimum training standards, that along with operational evaluation criteria, would designate those eligible for entry to practice. To that end, there are two categories of training experiences that should be included in the Transitional Council's evaluation – those that are formative and sufficient and those that are professionally supportive but insufficient.

1. **Formative Professional Development:** The essential educational experiences that comprise psychotherapy training are a combination of didactic coursework and supervision of clinical cases. This is intended to impart the knowledge, skills, attitudes and values that promote psychotherapeutic competence. Each modality of psychotherapy has a theoretical body of knowledge that must be mastered and its application in clinical treatment by therapists in-training must be supervised. A duration of two years of this type of training would be a minimum training period required.
2. **Continuing Professional Development:** Attending a brief training workshop or participating in a longitudinal seminar without case supervision would not contribute to the formative qualification for a psychotherapist, but would support continuing education once the professional designation had been attained.

10.3 Communications

The Transitional Council should implement a strategic communications program targeted to practitioners and members of the public to convey the following messages:

- The purpose of regulation is not to exclude currently unregulated practitioners. It is intended to bring them into a regulatory framework to support safe, effective and accountable practice in the public interest.
- Currently unregulated practitioners themselves will play a significant role in the transition to regulation, including a role in establishing qualifications and standards.

- Regulated practitioners will meet accountability standards established by existing Colleges.

11. Conclusions

Psychotherapy and psychotherapists are not regulated in any comprehensive or consistent way in Ontario. Anyone, with or without credentials, may practice psychotherapy and call him/herself a psychotherapist.

Psychotherapy is provided by a spectrum of practitioners, ranging from regulated health professionals (physicians, psychologists, social workers), to those with master's degrees in psychology plus specialized training in psychotherapy, and those who have little or no formal training.

Overwhelmingly, respondents to HPRAC's *Discussion Guide*, and speakers at public consultations told us that the practice of psychotherapy by unskilled practitioners poses a risk of harm to the public. Harm may result from inappropriate assessment and treatment, delayed referral to qualified professionals, and abuse of clients sexually, emotionally and financially. The potential for abuse is heightened when psychotherapy is practiced in isolation without supervision or peer support.

The potential for harm to vulnerable clients has been recognized by other jurisdictions, which are considering regulation or have introduced regulatory schemes.

HPRAC's analysis supports a conclusion that the potential for harm by unskilled or unscrupulous practitioners of psychotherapy calls for regulatory intervention. HPRAC has examined a number of regulatory options, including: 1) the creation of a registry 2) amending the *RHPA* harm clause; 3) title protection; 4) title protection with scope of practice; 5) regulating unregulated practitioners under an existing College; and 6) designating a new controlled act for psychotherapy under the *RHPA*.

HPRAC evaluated these options while weighing the public interest, the need for professional accountability, and access issues. HPRAC concluded that title protection and an enforceable scope of practice provide the best balance, and that the most appropriate statutory vehicle is the *RHPA*, which provides a comprehensive yet flexible approach to regulation.

Following a reasonable transition period, during which practitioners would be asked to submit information to the Transitional Council as part of a provincial Registry or List, HPRAC recommends that a permanent regulatory body, the College of Psychotherapists, be established.

One of the first steps in the regulatory process would require existing regulatory Colleges whose members practice psychotherapy (College of Psychologists of Ontario, College of Physicians and Surgeons of Ontario, Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario) to develop high minimum qualifications, general practice guidelines and continuing competence requirements specific to the practice of psychotherapy for their members who practice psychotherapy. This could be accomplished by means of a directive from the Minister under a provision of the *RHPA*.

A collaborative interdisciplinary approach to the practice of psychotherapy by Colleges is fundamental to protecting the public interest, and ensuring that people who need psychotherapeutic services can rely on qualified practitioners from a range of disciplines.

A critical consideration is the need for public education, including how to find a qualified practitioner, clients' rights and how to lodge a complaint against a practitioner. A public awareness campaign on the process leading to regulation will be essential for both practitioners and members of the public.

12. Recommendations

HPRAC recommends to the Minister:

1. That psychotherapy and psychotherapists be regulated under the *Regulated Health Professions Act*.

2. That a College of Psychotherapists of Ontario (Ordre des psychothérapeutes de l'Ontario) should be established.

3. That an enforceable scope of practice of psychotherapy should be defined in the Act, and that the scope of practice should restrict the practice of psychotherapy to certain regulated professionals, and that an exemption for certain activities should be included as follows:

    (1) Psychotherapy is the provision of a psychological intervention or interventions, delivered through a therapeutic relationship, for the treatment of cognitive, emotional or behavioural disturbances.

    (2) No person other than a member in good standing of the College, the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who has met the qualifications specific to the practice of psychotherapy as established by their College shall engage at any time in any of the activities as set out in (1).

    (3) The Act does not apply to counsellors providing information, encouragement, advice or instruction about emotional, social, educational or spiritual matters.

    (4) Notwithstanding (3), treatment that goes beyond the bounds of counselling should not be exempted.

4. That the Council of the College should be composed of (a) at least six and no more than nine persons who are members elected in accordance with the College's by-laws; (b) at least five and no more than eight persons appointed by the Lieutenant-Governor-in-Council who are not members of the College, another College or Council under the *RHPA*.

5. That the Council of the College should establish an Advisory Committee to include representatives of the College of Psychologists of Ontario, College of Physicians and Surgeons of Ontario, Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario.

6. That the Council should have a President and Vice-President elected annually by Council from among its members.

7. That every member of the College who practices psychotherapy or resides in Ontario and who is not in default of payment of the annual membership fee should be entitled to vote in an election of members of the Council.

8. That the use of the title "psychotherapist" should be restricted to members of the College and members of the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who are qualified to practice psychotherapy.

9. That a person who is not a member of the College, or a member of the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who practices psychotherapy should not represent him or herself as a person who is qualified to practice psychotherapy in Ontario.

10. That the Lieutenant-Governor-in-Council, on recommendation of the Minister, should appoint, for a period of three years, a Transitional Council, Chair and Vice-Chair.

11. That the Transitional Council should be composed of a Chair; a Vice-Chair; at least six and no more than nine persons who are currently unregulated practitioners of psychotherapy; at least four and no more than six persons who are nominated by the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario; and at least five and no more than eight persons who are not currently unregulated practitioners of psychotherapy or members of a regulated College or Council under the *RHPA*.

12. That the Transitional Council should have the authority to appoint a Registrar and the Registrar and the Council's committees should have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

13. That the Transitional Council and its employees and committees should have the authority to do anything that is necessary or advisable until the Council is established.

14. That upon appointment of its members, the Transitional Council should move immediately to develop:

    (a) A list of currently unregulated psychotherapists including the names of persons who practice psychotherapy, their education and training, billing practices, as well as the form of psychotherapy that each registrant practices.

    (b) High minimum qualifications for the practice of psychotherapy.

    (c) General standards of practice for psychotherapy.

    (d) Quality assurance programs for psychotherapy.

    (e) The educational qualifications and equivalency standards to address the registration of currently unregulated practitioners.

15. That the Minister of Health and Long-Term Care should issue a direction under section 5 (1) (d) of the *RHPA*, and the Minister of Community and Social Services should issue a direction under Section 11 of the *Social Work and Social Service Workers Act*, requiring the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Social Workers and Social Service Workers and the College of Nurses of Ontario to establish high minimum qualifications and general standards for the practice of psychotherapy in their professions.

16. That where one or more of those Colleges, in the opinion of the Ministers, fails to establish the qualifications and the necessary mechanisms to implement and enforce these qualifications and standards within the time specified by the Ministers in their directives, the qualifications established by the College of Psychotherapists should be deemed to apply.

17. That subject to the approval of the Lieutenant-Governor-in-Council, and with prior review of the Minister, the Council of the College of Psychotherapy of Ontario should be authorized to make regulations

    - Prescribing high minimum qualifications for the practice of psychotherapy.

    - Prescribing and governing the therapies involving the practice of the profession and prohibiting other therapies.

    - Exempting modalities that do not constitute the practice of psychotherapy.

    - Adding protected titles.

    - Any matter relevant to the profession of psychotherapist and/or the practice of psychotherapy.

18. That complementary amendments should be made to the *Nursing Act, 1991*, *Medicine Act,1991*, *Psychology Act,1991* and *Social Workers and Social Service Workers Act, 1998*.

REGULATION OF PERSONAL SUPPORT WORKERS

The Minister's Question

The Honourable George Smitherman, Minister of Health and Long-Term Care, requested advice from the Health Professions Regulatory Advisory Council (HPRAC) regarding the regulation of personal support workers. HPRAC was asked to:

> Review the range of work carried out by Personal Support Workers (PSWs) and make initial recommendations on whether all or some part of this range would indicate that Personal Support Workers should be considered for regulation under the [*Regulated Health Professions Act, 1991] RHPA.*[1]

HPRAC's Response

Some 100,000 individuals in Ontario are described as personal support workers, and their work is varied. Many provide assistance with activities of daily living, such as housekeeping, laundry, and personal care such as bathing. Others, however, provide health care, including performing controlled acts, under the supervision of regulated professionals. No personal support worker is supposed to independently initiate or execute health care; rather, they are intended to follow a care plan that has been developed specifically for the patient or client and to be supervised by a regulated professional in delivering care under that plan.

The variation in work settings, including long-term care homes, private residences, retirement homes, and hospitals, with differing degrees of regulatory oversight and inconsistent standards, and the increasing complexity and vulnerability of the patient and client population complicates responses to the Minister's question. The training base of PSWs, (with approximately 20 percent of the PSW workforce having received formal education in community and career colleges or through continuing education programs through school boards, and the remainder through in-service training) has led to uneven skills through this occupational group.

PSWs are a critical component in the provision of home care, long-term care and other community health care services. The disparate nature of the workforce, service funding, and patient safety matters must be taken into account in considering the request made by the Minister. HPRAC has completed the initial phase of work in response to this request, and will offer final recommendations in September, 2006.

---

[1] Minister's Referral Letter, February 2005, Appendix A

1. HPRAC's Approach to the Question

HPRAC initiated a two-phase project to address the request from the Minister.

Phase I investigated the range of work carried out by PSWs. It explored the size and composition of the workforce, the range of tasks and services performed in various settings, and the education and training pathways that lead to employment as a PSW. It provided an initial overview of areas of concern relating to the work of PSWs, and an initial discussion of the need for regulation, whether current regulation was adequate or inadequate and possible alternatives to regulation.

Phase II continues. It involves broad public consultation followed by a more detailed analysis of the scope of work performed by PSWs, their supervision, and an assessment of the appropriateness of regulation in certain circumstances. In particular, the Advisory Council is looking for input from PSWs themselves, and patients and clients who use their services. Phase II will conclude in early summer, 2006 followed by a comprehensive recommendation to the Minister.

1.1 The Consultation Process

Initially, interested parties were invited to preliminary interviews to provide background information, and multiple perspectives on PSWs. Interviewees were selected to be as representative as possible and included organizations and associations representing providers, consumers, education and training institutions, facilities, disease support organizations, advocacy associations, regulated professional colleges, health professional associations, labour organizations, and PSW representative groups.

The information provided was reflective of the experience of individual organizations and included demographics, roles and responsibilities, work environment, educational requirements, guidelines governing PSW work, client descriptions, and current issues facing PSWs. Some early comments were received concerning the extent of regulation now affecting the sector, and where additional steps may or may not be useful.

Workshops were held to assist with the development of a Discussion Guide that was posted on the HPRAC web site and circulated for response. Members of the public, organizations, and those with an interest in the question were invited to respond. The Guide highlighted questions regarding risk of harm, the changing health care environment, variability of work, human resource challenges and education and training.

HPRAC received 43 written submissions from employers, regulated health professions, consumers, educators, and representatives from interest and advocacy groups. In addition, thirty-two interviews were conducted with experts in various subjects relevant to the field.

These activities provided substantial feedback on what key stakeholders felt are matters of concern. Contributors commented on the:

- Role of PSWs and the work they perform;
- Potential for harm to a patient or client;
- Current legislation that impacts PSW employers and facilities where they work; and
- Alternatives to regulation under the *RHPA*.

In addition, a review of other jurisdictions and current literature was undertaken. Material from Nova Scotia, USA, UK and Australia was reviewed and analysed to determine how regulation had been approached for workers similar to PSWs. Further lessons were learned from some jurisdictions where various regulatory interventions had been introduced. Discussions were held with representatives from Nova Scotia to gain an understanding of their attempts at standardizing education for PSW-like workers.

2. Background

Personal Support Workers were previously known as health care aides, personal attendants, home supporters, respite care workers, palliative care workers, supportive care assistants and by other titles. These titles more specifically defined the work undertaken by a person who is now generically described as a Personal Support Worker.

In 2004, the Ministry of Training, Colleges and Universities (MCTU) published its PSW vocational, employability and general education standards. The preamble to the vocational standards indicates:

> Personal support workers are unregulated health care providers. They work under the supervision of a regulated health professional, supervisor, or, in the supported independent living environment under the direction of the client. They provide clearly identified personal care, routine activities of living, and home management services, by following care/service plans and established policies and procedures. Personal support workers are responsible for their work to their clients and to their employers. Employers and supervisors, when assigning work to personal support workers, consider each client situation in relation to that client's condition, the task to be done, the associated risk of performing the task, and the environmental supports required to safely and competently carry out the task. In carrying out their assigned work, personal support workers are responsible for safely and competently following care/service plans, oral directions and written guidelines, and for complying with established policies and procedures. Personal support workers cannot perform a controlled act (*Regulated Health Professions Act, 1991*) unless the authority is delegated to them by a regulated health professional who, in making this decision, has used the practice specific guidelines outlined by their regulatory body.[2]

---

[2] Personal Support Worker Program Standard, MCTU, December, 2004

This definition, and the educational programs that are a part of it, encompasses many aspects of PSW work, from assistance with activities of daily living (ADL) to direct, front-line delivery of health care services.

2.1 The Workforce

Information collected from a number of sources, including reports from long-term care homes, employer and association websites and relevant studies, indicates that there are approximately 100,000 people currently employed as PSWs in Ontario, some of whom may work under different titles, such as health care aide, or attendant care provider. Because a number of PSWs are hired privately and are difficult to track, the total number of PSWs may in fact be higher.

Health Canada data indicates that this is a rapidly growing sector with a low unemployment rate. The sector primarily employs large numbers of new immigrants who speak English as a second language as well as people with less formal education. The majority of PSWs have not completed a formal training program. Some rely on previous work in related occupations, and others bring healthcare training received in another country. Many are trained in-service by employers or through not for profit organizations.

In Ontario, approximately 57,000 PSWs are employed in long-term care homes, where they provide the bulk of direct care to individuals with a high need for personal care and support. Three quarters work full time, and close to 90 percent of the workforce is female. Clients may have care needs ranging from chronic disease management to dementia care.

Close to 24,000 PSWs work in home care in Ontario. Sixty-three percent are employed full-time and the workforce is 92 percent female.[3] A recent study indicates that many work under the elect-to-work model, where they can choose their hours, but are not entitled to severance or holiday pay. Some prefer these flexible schedules, while others work for multiple employers to obtain the desired number of hours.[4]

2.2 What is a Personal Support Worker?

There is no uniformly accepted definition of a personal support worker. The vocation is often defined by job descriptions on file with employers. These vary by sector and setting. The term also may relate to the educational background of the worker, implying that he or she has completed a PSW program. Several profiles were provided. They include:

- A Personal Support Worker is a caregiver who assists people with daily care needs as they deal with the effects of aging, injury or illness. A PSW works under the direction of a Registered Nurse or

---

[3] Ontario Job Futures. "6471 Visiting Homemakers, Housekeepers and Related Occupations". Government of Ontario. http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=6471.

[4] Realizing the Potential of Home Care, Report to the Minister of Health and Long-term Care 2005

Registered Practical Nurse.[5] [They may] assist nurses, hospital staff and physicians.[6]

- Personal Care Workers deliver quality care, assistance and support services to people in their own homes during times of need. The duties of home support workers vary according to the situation.[7]

- Personal Support Worker[s]…provide long-term care and support to patients and clients. Work responsibilities include personal care, housekeeping duties, shopping and companionship. The abilities of the Personal Support Worker are critical to the well being, comfort, safety and health of the people they support.[8]

- Home support is intended to serve more than individuals in need. It is supposed to act as a buffer against the strain on our hospitals, long-term care facilities, health personnel and provincial and territorial budgets.[9]

2.3 Roles Performed by Personal Support Workers

PSWs provide services and direct care to individuals in hospitals, long-term care homes, group homes, retirement homes, supportive living environments and in the client's home. They work with clients who have a broad spectrum of conditions and health care needs. Services may be provided on a temporary or continuing basis.

Some of the functional tasks performed by PSWs are:

- **Activities of daily living (ADL)** – personal care (bathing, feeding, dressing, toileting), transferring (walking), light housekeeping and child care.

- **Instrumental activities of daily living (IADL)** – menu planning, shopping, meal preparation, providing transportation or accompanying clients, educational and recreational assistance.

- **Clinical care services** – measuring a client's blood pressure, temperature or pulse, or taking specimens.

- **Delegated acts** – administration of suppositories, colonic irrigations, enemas (bowel disimpaction), or medications; maintaining inventories; and supervising exercise routines.[10]

---

[5] Ontario Network for Internationally Trained Professionals Online. *Personal Support Worker.* http://www.onip.ca/article/8/.

[6] Ontario Job Futures. *3413 Nurse Aides, Orderlies and Patient Service Associates.* Government of Ontario. http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=3413.

[7] Canada Career Consortium. *Home Support Worker/Home Health Aide.* http://www.careerccc.org/careerdirections/eng/e_oc_dwn.asp?ID=97&Alpha=No.

[8] Ontario Hospital Association. Health Care Job Descriptions. http://www.oha.com/client/OHA/OHA_LP4W_LND_WebStation.nsf/page/Health+Care+Job+Descriptions

[9] Canadian Association for Community Care. Canada Home Care Labour Market Study. 1995.

[10] Ontario Job Futures. *3413 Nurse Aides, Orderlies and Patient Service Associates.* Government of Ontario. http://www1.on.hrdc-drhc.gc.ca/ojf/ojf.jsp?lang=e&section=Profile&noc=3413.

The variation in these functions demonstrates a clear difference between personal care, home support and health-care functions.

The variation in their work settings contributes to the complexity of classifying PSWs. Changes in the delivery of home health care and support and the changing client profile also affects the role of PSWs. The increase in patients being discharged early from hospitals may increase the acuity of home care clients and the complexity of services provided. In long-term care homes, there is an increased focus on chronic disease management and dementia.

Long-Term Care

Clients in long-term care homes have a high need for personal care and support that may include chronic disease management, medication management and dementia care. In this environment, the scope of work for PSWs includes assistance with activities of daily living (ADL), recreation, ambulation and carrying out delegated nursing acts.

The average age of residents in long-term care homes is seventy-five years, and many require ongoing health care services. Greater diversity among the resident population within LTC homes also calls for a more diverse skills-set among the PSW workforce.

The majority of PSWs working in long-term care homes have community college certificates. Follow-up training is usually provided by the employer. Because workers are often unionized, compensation may range from $14.85 per hour for PSWs without a certificate to $15.00 per hour for those with a certificate.

There are a number of regulations, legislation and standards in Ontario that impact long-term care homes. Recently, new clinical measurement systems have been introduced.

Community Home Care

There are three main categories of employers in the community home care sector.

Community Care Access Centres

A significant number of PSWs working in home care are employed by agencies contracted by Community Care Access Centres (CCACs). These agencies hire PSWs to work in patients' homes, where they are primarily responsible for ADL, instrumental activities of daily living (IADL), and client-specific personal and or clinical care needs. The client population varies widely. The number of post-acute clients is increasing as a follow-up to ambulatory procedures and as patients are released more quickly from hospitals. Many clients require on-going care to manage chronic conditions. Clients span all age groups. Approximately 25,000 PSWs work in CCAC-directed Home Care.

Community Support Agencies

Community Support Agencies hire PSWs to provide services primarily to the elderly and individuals living with physical disabilities. The role of the PSW varies with the agency's mandate. Some agencies provide home help. Other agencies provide respite care.

In each of these situations, the PSW is likely to provide IADL and ADL assistance. Given the diversity of these agencies, it is difficult to quantify the number of PSWs working for community support agencies. Estimates are approximately 10,000.

Attendant Care Agencies

Attendant Care Agencies also employ PSWs. These agencies primarily administer outreach attendant care and assisted living programs for the adult disabled community living in supportive housing. They also play a role in the province's Direct Funding Program.

Attendant care workers may support clients with ADL, IADL and personal care, but their relationship is based on the independent living model, not a health care model. Clients participating in the Direct Funding Program hire their own attendants and, at all times, direct their actions. In these situations, attendant care workers may perform controlled acts by exception, and delegation from a regulated health professional is not required. Currently, there are seven-hundred individuals in Ontario receiving funding through the Direct Funding Program.

The majority of PSWs employed in the community home care sector either hold a college certificate or have previous experience in client-based care. Additional training is often provided by employers to help meet client-specific needs.

Irregular hours and a comparative wage disadvantage have led to a high turnover rate. Many PSWs employed in this sector work split shifts and hold multiple jobs. Compensation ranges from $11.50 per hour to $15.20 per hour, depending on the geographic location.

Hospitals

In hospitals, PSWs work primarily in rehabilitation and complex continuing care, and are generally known as health care aides. In these settings, PSWs support ADL and activation activities. There are 6,115 PSWs in 157 hospitals in Ontario. As the result of higher wage rates ($17.23 per hour to $18.36 per hour), hospitals are often able to recruit PSWs from other care settings. Turn-over for PSWs in hospitals was 6.9 per cent in 2005.[11]

---

[11] For full-time and part-time PSWs in hospitals.

Other

PSWs may be employed privately by clients living in retirement homes, group homes or other situations. In these cases, salaries are paid directly by the clients or subsidized by other funded programs, such as the Department of Veteran Affairs (DVA). Clients who utilize these services require help with ADL, IADL, homemaking duties (such as laundry, cleaning and grounds-keeping), recreation and socialization. In this context, health care is not the primary focus of the services provided. Due to the number and variety of settings, it is difficult to quantify the number of PSWs employed in the sector and their compensation levels.

2.4 Education and Training

Typically, personal support workers prepare for the job in one of two ways, through in-service (employer-based) training,[12] or in classroom programs offered by community colleges, Boards of Education, private colleges and not-for-profit organizations.

In-service training

Most employers provide orientation and training or skills upgrading instruction relevant to the specific needs of their clients. Employers may subsidize costs for employees for skills upgrades acquired through formal education. Other PSWs may be enrolled in an education program as part-time students while working on a part-time basis. A large proportion of PSWs have received in-service training offered by their employers, either through direct on-the-job training or through formal programs offered through non-governmental health organizations. For example:

- The Canadian Diabetes Association (CDA) provides in-service programs for PSWs who are employed in long-term care homes.
- The Oaklands Regional Centre (Oakville, Ontario) supports skills development through additional college courses in pharmacology, behaviour modification, and program planning to assist in the care of developmentally challenged adults.

The recent study, *Commitment to Care*, recommends training requirements for PSWs in the long-term care environment. At a minimum, staff should be trained to understand the needs of the elderly, abuse, communication skills, dementia and palliative care.[13]

---

[12] May include basic skills acquisition as well as progressive skills acquisition.

[13] Smith, Monique. Commitment to Care: A Plan for Long-term Care in Ontario. Ontario Ministry of Health and Long-Term Care. 2003.

Community Colleges

In 1997, the Personal Support Worker Program consolidated and replaced five courses of home care training.[14] In 2005, the Ontario Ministry of Training, Colleges and Universities (MTCU) updated its 1997 standards for programs graduating PSWs.

PSW Programs are offered at twenty-two community colleges. The programs are usually taught over two academic terms (approximately eight months). Reportedly 2,272 students graduated from PSW programs in 2002-2003 in Ontario. On average, graduates spent 384 hours on in-class theory[15] and 386 hours gaining practical experience for a total of 770 program hours. Individuals working as personal attendants may have completed a program that is similar to that of the PSW but shorter in duration.

Private Career Colleges

Ontario's private career colleges are overseen by the MTCU, and receive program approval based on a demonstrated minimum curriculum. They are not required to match the community college program standards, but recent evaluations indicate that most meet all core elements. The National Association of Career Colleges (NACC) provides a core curriculum against which career colleges may measure their programs, but it is not mandatory for career colleges to implement the NACC curriculum. Currently, 121 private career colleges offer PSW programs. The NACC program is approximately 640 hours in duration, with 355 hours spent in the practicum component and 285 hours spent in learning theory. Since 1998, approximately 17,000 PSW graduates have passed the final examination offered by NACC.[16]

Boards of Education

Twenty-one Boards of Education offer PSW courses through Adult Continuing Education programs. Courses contribute to the completion of a high school diploma. The Toronto District School Board graduates approximately 150 personal support workers a year. The Simcoe County School Board provides a personal support worker program connected with Georgian College.[17]

> …School board and not-for-profit training programs…train over 2,300 PSWs annually – approximately 40% of those trained each year. Their exclusion would significantly reduce the supply of PSWs.
>
> Ontario Community Support Association

---

[14] This program replaced the Home Support II and III programs, the Health Care Aide program, Attendant Care Training and Respite Worker Training, resulting in the emergence of the title of Personal Support Worker. Ontario Association of Community Care Access Centres, Ontario Community Support Association, Ontario Home Health Care Providers' Association: *The Role and Value of Homemakers/Personal Support Workers in the Health Care System: A Discussion Paper*. November 2000.

[15] Theory hours include non-vocational components that teach skills identified by Human Resources and Skills Development Canada as requirements for employability across Canada.

[16] National Association of Career Colleges. *About NACC*. http://www.nacc.ca/about.htm. Interview with the Private Colleges Branch of the Ministry of Training, Colleges and Universities.

[17] Simcoe County District School Board. *School to Work and OYAP*. http://www.scdsb.on.ca/programs/school_to_work.cfm.

Boards of Education may adhere to the MCTU's PSW program standards or they may opt to offer the Ontario Community Support Association curriculum developed with MOHLTC and implemented in 1997.

Typically, students enrolled with a Board of Education will spend 540 hours in the classroom and 270 hours completing their practicums.

2.5 National Association of Certified Personal Support Workers (NACPSW)

NACPSW is a voluntary, non-profit membership association for PSWs involving some 5,000 PSWs across Canada. The association's model is that of a self-regulatory volunteer association. It has made efforts to standardize the qualifications of its members, who must complete an approved education program, pass a certification examination and participate in continuing education programs. Approximately twenty career colleges have opted for the NACPSW curriculum.

To become a member, a PSW must complete a 1,000 hour course that includes fourteen modules. Program hours are equally divided between academic preparation and work in community and institutional settings. The theory component includes generic studies comparable to those of community colleges along with courses in anatomy, physiology and disease processes. Roughly three weeks of work are supervised. A minimum of 75 per cent is needed for both academic and applied components. Following completion of the standardized examination, the member is certified by the association.[18]

It should be noted that the NACPSW has not made a request to the Minister for regulation of the profession. HPRAC observes that while NACPSW is in the early stages of advocacy activity as a voluntary organization, it has not yet captured a significant population of eligible membership, and may face similar challenges to those experienced by HPRAC in defining its membership and the scope of work included in their employment.

3. Factors Informing HPRAC's Recommendation

Discussion of the following factors indicated to HPRAC that broader consultation and further discussion of the appropriateness of regulation is warranted.

3.1 Risk of Harm

PSWs perform a number of essential and personal tasks. They are often the principal attendant or caregiver for a client at home or in a facility. Clients may be particularly vulnerable because they are frail elderly, have physical or cognitive disabilities or are recovering from illness or injury.

---

[18] National Association of Certified Caregivers/Personal Support Workers. Who Are We? http://www.nacpsw.org/.

For the most part, patients do not require in-hospital care. PSWs work under the direction of their employer, a regulated health professional, the client or a family member.

In a private home setting, in particular, there may be little direct supervision, and the PSW may not be able to quickly obtain advice in an urgent situation. If the quality of care is of concern, the client or members of his or her family may not know how to make a report or complaint, although the *Long-Term Care Act, 1994* requires that CCAC's, community support agencies and long-term care homes provide advice about complaints processes. Several intervenors commented that because complaints are made to employers in these circumstances, an inherent or potential conflict of interest exists.

Services provided by some PSWs now incorporate functions previously provided by others, including regulated health professionals. If PSWs are not sufficiently trained, clients and patients can be put at risk of harm. A PSW may be the only caregiver present when a client or patient experiences a change in condition. The PSW response may directly affect the health outcome of the individual in these situations.

Contributors to HPRAC's consultations pointed to research demonstrating that persons with disabilities are more likely to experience abuse compared to persons without disabilities of the same age and gender.[19, 20, 21] Abuse may take the form of physical abuse, harassment, neglect and financial abuse. There is evidence that much of this abuse is experienced in their interactions with caregivers.[22]

> In the last five years, [we have] been contacted over 400 times regarding an abusive situation or incident involving persons with disabilities. Many of the calls we receive are from individuals who have experienced abuse in the context of their receipt of services from PSWs. The nature of complaints we have heard include:
>
> - an individual being dropped and banged resulting in substantial injuries when a PSW transferred him out of bed;
> - an individual being told he was worthless because of his disability;
> - an individual being left in bed for several days because of a refusal to transfer him out of bed.
>
> ARCH Disability Law Centre[23]

---

[19] Liz Stimpson & Margaret Best, *Courage Above All: Sexual Assault Against Women with Disabilities* (Toronto: DisAbled Women's Network (DAWN), 1991) at 6. DAWN estimates that 83 per cent of women with disabilities will be sexually abused in their lifetime.

[20] Roeher Institute, Harm's Way: The Many Faces of Violence and Abuse against Persons with Disabilities (North York: Roeher Institute, 1995) at 8. The Roeher Institute suggests that 60% of persons with disabilities are likely to experience some type of violence in their adult lives.

[21] Doris Rajan, Violence Against Women with Disabilities – Overview Paper (Ottawa: Minister of Public Works and Government Services Canada, 2004) at 2, online: National Clearinghouse on Family Violence < http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/pdfs/2005femdisable_e.pdf >.

[22] Leslie Myers, Caregiver Abuse: A New Dimension to Services for Domestic Violence Agencies, *Independence First* 2003.

[23] ARCH Submission to HPRAC, March 17, pg 5.

ARCH goes on to say "it is almost certainly the case that abuse [involving] ...PSWs is substantially underreported." The Centre is frequently told that the vulnerable do not want to formally report the abuse for fear of reprisal, such as further abuse or loss of services. The fear of reprisal is also heightened in settings where the option of having an abusive staff member replaced does not exist because of limited staff availability or rules governing unionized workplaces.

3.2 Supervision

The nature of the supervision received by personal support workers varies substantially. In certain settings, a PSW may be supervised by a regulated health care professional, for example, a registered nurse. In this case, the nurse would determine the competency of the PSW before requiring or allowing her to provide certain types of care or treatment. Where the nurse is confident in the abilities of the PSW, the nurse might delegate the performance of a controlled act or other tasks such as administering medications or changing dressings.[24]

Frequently, however, the PSW is working at some physical distance or with limited oversight from the supervising health professional. Contact between the PSW and the supervising professional may be limited to reviewing notes on the client's progress – in the absence of the client and away from the client's living environment. Further, the supervising health professional may not have seen the patient, or been aware of particular circumstances regarding the provision of care to the individual. The PSW most frequently does not participate in team consideration of the person's progress or development of the care plan, and may not have full information as a benchmark for reporting change.

In other circumstances, a PSW may be employed directly by a client or patient without supervision by a regulated health professional. In these circumstances, a PSW may provide advice or services to a patient that should be provided by a person with more extensive qualifications.

3.3 Qualifications

Entry to practise standards are a method of introducing accountability and managing risk, particularly in environments where clients may be vulnerable.

There is no definitive body of knowledge unique to the work of a PSW and there is a great deal of variation in basic education and training for the occupation. At the formal educational level in Ontario, there are four program models and no province-wide qualifying exam. There is no authoritative accrediting body that recognizes the curriculum offered by various educational providers.

---

[24] Ontario Association of Community Care Access Centres, Ontario Community Support Association, Ontario Home Health Care Providers' Association. The Role and Value of Homemakers/Personal Support Workers in the Health Care System. Ontario: OACCAC, 2004.

Many PSW employers do not require PSW personnel to have formal educational qualifications but may offer in-service training or rely on the PSWs past work history as evidence of the ability to perform the work safely. Employers may have difficulty assessing equivalent competencies for workers with differing backgrounds, or experience and training outside of Ontario or Canada.

Stakeholders identified several gaps in the PSW skills set including:

- Teamwork, communication and literacy skills;
- Poor understanding of human growth and development across the lifespan;
- Poor understanding of people living with disabilities; and
- Insufficient knowledge of specific care issues associated with palliative care, alzheimer's and dementia.

Body of Knowledge

In contemplating advice to the Minister regarding regulation of health professionals, HPRAC considers whether there is a distinctive, systematic body of knowledge in assessing, treating or serving a professional group's clients or patients. Core activities must be discernible as a clear integrated whole and must be broadly accepted as such within the profession.

The College of Nurses of Ontario observed that "PSWs do not practice within a distinctive systematic body of knowledge, but [follow] a clearly defined plan of care defined by the employer and/or supervisor."[25]

> The work of PSWs is directed by a plan of care developed by a regulated care provider. The PSW does not organize the care plan but is responsive to it in support of the client. The PSW does not perform an assessment.

Others have responded that PSWs are responsible for charting patient progress, and that the supervisor is rarely available for comment or to discuss the progress of a patient, and therefore the PSW input, gained from daily contact with the patient, is frequently not taken into account in the development of care plans or their implementation. The development of a care plan is significantly removed from the implementation and supervision of the plan as it is carried out. While PSWs may not perform assessments, it is clear that they observe trends, changes and needs of the person to whom they provide care. They may have little assurance that their observations are taken into account.

---

[25] College of Nurses of Ontario, Response to Consultation Discussion Guide, March 2006, pg 4.

3.4 Independent Living in the Disabled Population

PSWs, as currently defined, are major service suppliers to persons living independently with disabilities. Many people living with disabilities argued strongly that current ADL exceptions from the controlled act provisions of the *RHPA* should continue so they can freely direct their personal care and provide instruction and direction to PSWs who provide attendant care. Their autonomy and independence should be such that people with disabilities are not regarded as patients or simply recipients of services, but rather have choice and control over the way their disability-related needs are met.

The Ontario Community Support Association indicates that the risk associated with the routine tasks performed by attendants "is generally no greater than the risk incurred if the client were to perform the activity him or herself."[26] The Independent Living Service Providers notes that "...this exemption has served attendant care employers and clients very well since 1991."[27]

On the other hand, others have indicated that people living with disabilities should be assured that people providing their care have appropriate training, and that there are mechanisms for recourse in the event of client abuse or substandard care.

3.5 Increasing Complexity and Variability of Work

There are a number of reasons for the increased complexity of work performed by PSWs. Supply shortages within the regulated health care professionals have led employers to give PSWs increasingly complex tasks.

Increasing demands for services also follow from an aging population, a desire among clients to remain in their homes as long as possible, and convalescence following early hospital discharge. Employers, including CCAC agencies and long-term care homes seek to hire more PSWs, and employ them in a broader scope of work. As well, HPRAC was told, competitive pricing between service delivery agencies has meant that agency-employers may substitute lower-wage employees such as PSWs for more highly skilled and expensive workers.

Many respondents observed that it is important that PSWs provide services that they are competent to perform, and that their skills must be equal to the tasks assigned.

3.6 Conclusions

HPRAC concluded that there is a potential for harm in the health services PSWs provide, and the adequacy of supervision provided by regulated health professionals and employers warrants further investigation. While achievements in education and training have been significant in recent years, HPRAC wants to review additional options for further standardized core elements, and whether additional specialization may or may not be needed to meet increasingly complex care needs.

---

[26] OSCA, *Response to the HPRAC Discussion Guide Regarding Personal Support Workers*, March 2006, pg 3.

[27] Independent Living Service Providers, *Submission to HPRAC regarding the Regulation of Personal Support Workers*, March 2006, pg 5.

In Ontario, there are a few emerging voluntary advocacy associations supporting PSWs. Their leadership seeks regulation, but may confuse the activity of a regulatory body with effective work of a voluntary advocacy association. In its initial review of the Minister's questions regarding PSWs, HPRAC has heard from employers, agencies and professionals, but has to date received little information directly from clients, patients and PSWs themselves. HPRAC is convinced that information from these sources is essential to preparing advice to the Minister.

In regard to attendant care services, the Advisory Council has considered the compelling arguments of physically disabled individuals who direct their own care and have attendants to assist in meeting their personal needs. For these people, the dignity, independence and choice that is provided as a result of the *RHPA* exception to the controlled acts is fundamental to their daily life. HPRAC has heard of no reason to change this provision, that was included in the statute in 1991 after intense examination and broad participation in the discussion. Therefore, HPRAC recommends to the Minister:

1. That there should be no change to Section 29 (1) (e) of the *RHPA* that excepts individuals "assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2)."

4. The Question of Regulation

HPRAC discovered that intervenors wanted to address the question of whether or not regulation in some form was required for at least some categories of PSWs. A number of responses to the Discussion Guide set out possible alternatives to regulation under the *RHPA* as appropriate mechanisms to mitigate the risk of harm, and to address other issues of concern. Others spoke to existing regulatory vehicles that govern the work of PSWs or the places where they work.

4.1 Preventing risk of harm

Implementing Best Practices

Employers suggested greater emphasis on management strategies and procedures to promote excellence in care, including client satisfaction surveys, formal complaints processes, planned visits and supervisor spot checks. They also suggest better needs analysis and documentation of the activities performed for clients (taking various risks into account), including ongoing evaluation and corrective action as needed. Positive feedback should be encouraged as well. Policies of zero tolerance of abuse, supplemented with training on abuse recognition were recommended.

Building Teams

Respondents urged employers to implement policies that encourage cooperation between care providers within their organization. Introduction of an integrated team model and the coordination of client services were two examples provided.

Moreover, it was recommended that employers support the participation of PSWs in care teams by recognizing them as an essential part of the team with clear and consistent performance guidelines, "achievable" workloads, and compensation commensurate with the risk and education associated with the role.

Lastly, it was proposed that, by hiring staff from different disciplines (e.g., nurses and PSWs) from single agencies, employers may have a better chance of promoting continuity of care through collaboration.

4.2 Improving Supervision

Strengthening Employer Accountability

Many respondents suggested that the risk of harm is best addressed by employer-sponsored training that encourages adherence to best practices in service by employees. This would include safe and ethical client care. As a prerequisite, employers called for increased funding for programs and supervisors to monitor performance.

> A broad dialogue must commence amongst all those involved in the employer-employee relationship, including clients, advocates, union and arbitrators about the creation of best practices and zero tolerance policies related to abuse, an issue which is felt to underlay the question of regulation.
>
> Independent Living Service Providers

Setting a Baseline

Many respondents said it was particularly important to improve supervision in the community care setting. However, it was pointed out that optimum degrees of supervision based on client acuity have yet to be defined. This led some respondents to recommend that supervision requirements be standardized to eliminate differences between settings and between guidelines espoused by the different regulatory colleges. Again, an infusion of resources was seen as the first step to ensure appropriate levels of supervision of PSWs by regulated health professionals. Delegation standards were also addressed.

> The College supports more explicit standards for publicly funded personal support services that address expectations for employer recruitment and supervisory practices as well as covering standards for safe effective delegation of controlled acts to PSWs. Delegation standards must be developed with the involvement of appropriate regulatory colleges with enforcement mechanisms considered.
>
> The College of Dietitians of Ontario

4.3 Educational Standardization

Some stakeholders noted that a more standardized training program for PSWs could help develop clear performance expectations and accountabilities for PSWs in care teams. This would give other team members a better understanding of the PSWs' capabilities and responsibilities, particularly in regard to delegating controlled acts.

Many respondents recommended that employers should further commit to the training and supervision of support workers until they reach PSW status, most particularly in the first two years of hiring, thus removing the barrier of requiring full PSW status in the procurement process.

4.4 Addressing Access and Variability in Work

Graduated Levels of PSW

In order to address differences in the complexity of skills required of PSWs in various care settings and in providing care to patients or clients with a range of needs, some respondents recommended that different levels be created within the designation of PSW (e.g. Level I, Level II). These would be supported by additional educational requirements and recognition. Others felt that multiple levels within a PSW designation would lead to more confusion.

Defining the Role of the PSW

Given the blurring of roles and responsibilities between PSWs and other healthcare and service providers, some respondents recommended clearer delineation of the roles fulfilled by PSWs in various health care settings. Regulated health professionals felt that an increase in the ratio of regulated to non-regulated staff in chronic care settings would also help address this issue. Concern was expressed that PSWs are increasingly being asked to take on responsibilities in health care that are within the scope of practice of Registered Practical Nurses without the competencies to do so.

Supporting Employer Accountability

It was suggested that employers should be held accountable for providing continuous and appropriate training for PSWs as patient care needs change.

Employer accountability depends on a commitment from employers to follow through and implement the necessary policies, procedures and protocols. Stability in the workplace is also required to achieve results. Respondents noted that where public policy and CCAC procurement processes detract from this goal, they should be modified.

Addressing Job Stability Issues

Some employers commented that the renewal of contracts through a competitive bidding process, in community settings, inhibits training efforts. Job uncertainty, along with difficulties in attracting staff in rural areas, may also undermine efforts to inculcate best practices.

Creating a Registry

HPRAC's initial consultations revealed a general interest in creating a registry of PSWs. The majority of stakeholders felt that the registry should be:

- Maintained by a central body;
- Accessible to employers wishing to hire PSWs;
- A resource for employers performing reference checks.

This would require development of a database that could house employer reports. The voluntary or compulsory nature of employers' participation in filing reports was somewhat controversial, as was the type of reports and timeframe for which records would be maintained. Confidentiality and immunity issues were not addressed.

There were mixed views on whether a register should be voluntary or compulsory. It was felt that PSW registration should be mandatory for all individuals who have successfully completed a PSW training program, or who are or wish to be employed as a PSW. Stakeholders felt that before a registry could be established, uniform minimum performance standards for PSWs would need to be confirmed. Additionally, the treatment of equivalent competencies would have to be addressed.

4.5 Effectiveness of Existing Regulatory Safeguards

Before the Minister's referral question can be properly addressed, HPRAC requires further discussion of the effectiveness of current regulatory safeguards. Current legislation in Ontario governs the facilities where PSWs work, employer obligations, and obligations on personal support workers themselves. Other statutory provisions protect the rights of persons receiving services and care. Some of these are outlined below.

Controlled Acts

The *RHPA* makes provision for an unregulated individual to perform a controlled act where he or she has been delegated the act by a regulated health professional who is authorized to perform the act.

In long-term-care homes and home care, PSWs may perform delegated acts; HPRAC has been unable to ascertain the frequency of such delegation, or the nature of training or supervision of the PSW in these circumstances. This requires further investigation.

Facilities and Employers

Several pieces of legislation, and the regulations and guidelines under them, govern the operation of facilities and institutions where PSWs are employed. Inspections of those facilities by the Ministry of Health and Long-Term Care and the Ministry of Labour are designed to ensure that occupational health and safety matters are addressed, and that the facility is in compliance with legislation, regulations and guidelines.

This provides a mechanism for accountability to the public for the standards within the facilities. Pertinent legislation includes the *Long-Term Care Act, Community Care Access Centres Act, Public Hospitals Act, Labour Relations Act, Employment Standards Act*, and *Occupational Health and Safety Act*.

However, none of these statutes addresses the competencies or qualifications of a PSW.

Workplace Practices

Policies may be put in place by employers as checks and balances. They may set minimum standards of service and behaviours by employees, including PSWs. CCAC's, long-term care homes, hospitals and other workplaces have internal policies regarding privacy, respect for patients or clients and patient safety. Many of these policies have been developed to address regulatory requirements demanded of employers.

Rights & Protection

The principles embedded in some legislation offer direction to PSWs in the performance of their duties, as well as guidance to Ontarians who rely on their services. Statutes and policies written to protect the rights of citizens and the consumers of social programs include, amongst others, the *Ontario Human Rights Code, Accessibility for Ontarians with Disabilities Act, Long-Term Care Act – Bill of Rights, Supportive Housing Policy, Developmental Services Act, Health Care Consent Act*, and *Personal Health Information Protection of Privacy Act*.

Where PSWs provide care to privately paying clients in their homes, civil or criminal law might also provide recourse for a client who has been subject to abusive or harmful actions by the worker.

4.6 Qualifications and Education Requirements

There is no standard curriculum across all PSW programs, although several efforts have been made by the various institutions. Less than 20% of PSWs working in Ontario have completed formal educational programs.

4.7 Options for Regulation

A number of options for the regulation of PSWs were reviewed during the initial consultation process and as a result of research findings. Some options include regulation, certification, and a registration roster.

Regulation

Regulation under the *RHPA* and profession-specific acts is one option. Regulated practitioners are required to have minimum entry-to-practise qualifications, and the use of specific titles is granted. Some stakeholders felt that standardized titles would help clarify the role of PSWs, and that creating levels reflecting increasing skills within a given title would be easier to understand than a proliferation of different titles. Continuing competency and quality improvement are a feature of regulation. In some cases, practitioners are regulated as a class within a college. Patients have a right of, and process for, recourse when problems arise through the complaints process of a college, in addition to civil remedies.

The establishment of a regulatory college includes financial obligations for members of a profession. The implications of this increased financial burden and the ability of a profession to sustain these costs must be considered when assessing whether the PSW occupation is suitable for regulation.

Certification

Certification is obtained through an authorized accrediting agency along with title protection. Non-certified individuals are allowed to perform the same services; however, they are prohibited from using the term "certified" and the designated title. There is no right of, or process for, recourse when problems arise, other than civil remedies. This mechanism is rarely used in Ontario for health professions.

It is important to indicate the difference between holding a certificate from an educational program and formal professional certification by an authorized body. The former is an acknowledgement of having completed an educational program while the latter is a designation provided by a certifying body that testifies that the individual is competent to perform a specific skill set. Some organizations may provide certification but are not themselves accredited.

Registration Roster

In the absence of a central accessible database or register for PSWs, it is often difficult for employers to obtain information about qualifications, work experience or reasons for leaving other employment. Employers may only have access to a criminal record check. The risk of harm to patients or clients may increase where employers are unable to perform full credential and work history reviews of PSW candidates.

A registration roster is the least restrictive form of regulation as it does not have extensive pre-entry competency screening and is not exclusionary. It requires individuals to file their names, addresses and other specified information with a designated agency. In some situations, information included in the roster is supplied by both the employer and the registrant. This mechanism is not currently used to regulate health professionals in Ontario.

5. Recommendations

HPRAC recommends to the Minister:

1. That there should be no change to Section 29 (1) (e) of the *RHPA* that excepts individuals "assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2)."

2. HPRAC has completed the initial phase of work in response to the Minister's request for advice, and will offer final recommendations in September, 2006.

REGULATION OF HEARING CARE

The Minister's Question

In his letter of referral of February 7, 2005, the Minister requested advice from the Health Professions Regulatory Advisory Council (HPRAC) on whether:

> in consideration of evidence of risk, the simple determination of a need for a hearing aid should be a controlled act, or whether, determining the specifications for a hearing aid, based on a hearing test and an assessment of the physical aspects of the ear, should be the controlled act. Also in consideration of evidence of risk, what aspects, if any, of hearing testing and dispensing of hearing aids should be controlled by the [*Regulated Health Professions Act, 1991*] *RHPA*.[1]

HPRAC approached this request in two parts.

1) Prescribing

   Currently, Ontarians obtain hearing aids either through a general prescription written by a family physician or general practitioner, or from a detailed prescription provided by an audiologist. The question from the Minister asks if general prescriptions (determining the need) should be replaced by detailed prescriptions based on audiological testing and assessment (determining the specifications).

2) Dispensing

   The referral requests HPRAC's advice on the matter of dispensing hearing aids. Currently not included as a controlled act, the Advisory Council considered whether the potential risks associated with dispensing hearing aids indicate that it should be included as a controlled act in the *RHPA*.

HPRAC's Response

HPRAC's response is that the evidence of risk does not support replacing the current controlled act of prescribing with a more detailed statutory definition, and that the act of dispensing a hearing aid should become a controlled act. HPRAC also recommends the regulation of hearing instrument practitioners (HIPs) in a revised College of Hearing and Speech-Language Professionals of Ontario along with audiologists and speech language pathologists.

---

[1] Minister's Referral Letter, February 2005, Appendix A

1. History of the Referral

When the *RHPA* was first developed, it was decided that only the act of prescribing a hearing aid needed to be controlled, with the intent that it be interpreted broadly. No other restrictions were considered necessary. Over time, there have been a number of requests respecting the regulation of hearing health professionals and for changes to controlled acts, from both audiologists and from HIPs.

Currently the only hearing health care procedure that is included in the list of controlled acts is "prescribing a hearing aid for a hearing impaired person."[2] Physicians, including family physicians, general practitioners and otolaryngologists (also known as ear-nose-throat or ENT doctors), and audiologists are authorized to perform this act. The meaning of "prescribing" in the controlled act of prescribing a hearing aid was considered by HPRAC in its 2001 advice to the Minister. At that time, the Advisory Council concluded that the intent of the legislation was to be flexible enough to allow either a generic or a specific prescription and held that "it is unnecessary to further define this controlled act."[3]

The Advisory Council also concluded that "it had not received any evidence to suggest that the public was being harmed as a result of the current controlled act for the prescription of a hearing aid."[4] HPRAC recommended that the Minister ask it to consider whether "determining the need for a hearing aid" or "determining the specifications for a hearing aid" should be a controlled act, based on evidence of risk. In February 2005, the Minister of Health made this referral.

Audiologists are currently regulated under the *RHPA*. They are members of the College of Audiologists and Speech Language Pathologists of Ontario (CASLPO). As evident in its name, CASLPO also regulates Speech Language Pathologists. The commonality between the professions of audiology and speech language pathology is that both deal with communicative disorders. Hearing instrument practitioners (HIPs) are not regulated under the *RHPA*. For some time, the Association of Hearing Instrument Practitioners (AHIP) has requested the regulation of HIPs under the *RHPA* in an independent college.

CASLPO responded to the Minister's current referral with recommendations calling for the replacement of general prescriptions with prescriptions based on a comprehensive audiological assessment; the creation of several new controlled acts; and the regulation of qualified unregulated hearing health care service providers by CASLPO. While in favour of regulation for its members, AHIP provided other options in its response to HPRAC.

---

[2] *Regulated Health Professions Act, 1991*, Section 27.2.10
[3] Adjusting the Balance: A Review of the Health Professions Act, Health Professions Regulatory Advisory Council, March 2001, Chapter 4, Pages 28-29
[4] Ibid

2. The Consultation Process

In response to the Minister's request, HPRAC invited submissions from stakeholders and the public, and received and analyzed 30 written submissions. A number of individual and joint meetings were held to obtain additional information and to clarify technical or other questions. Supplemental information was also requested and reviewed. Interviews were conducted with contributors who may not have responded to the request for submissions but whose input was considered relevant to the review. These included other professionals, academics and consumers.

HPRAC conducted a literature and jurisdictional review through which the regulatory regimes of 16 other jurisdictions (10 Canadian provinces, three U.S. states, Australia, New Zealand and the United Kingdom) were examined. On the question of risk of harm, HPRAC conducted two separate literature searches, and obtained and analyzed materials from academic, regulatory and professional associations. Informal focus groups with audiologists, physicians, hearing instrument practitioners, communicative disorder assistants, and consumers were held to augment information, and identify issues that required additional exploration. Additional information was collected through public hearings in HPRAC's Legislative Framework project.

3. Background

3.1 Hearing Health in Ontario

The demand for hearing health care is rising due to government infant screening programs and the growing number of elderly in the population. The complexity of hearing health care needs has also increased, as has the knowledge, training and technology available to prevent and manage hearing loss. Hearing health care has become a growing consumer business with greater expectations for regulatory oversight.

The number of individuals needing hearing health care in Ontario is expanding. Statistics Canada estimates that ten per cent of Canadians live with hearing loss. The Canadian Hearing Society estimates that closer to one in four individuals suffer some hearing loss. As we age, the incidence of hearing loss increases. Thirty per cent of persons aged 65 and older, and half of the population over 75 years have a hearing loss. As Ontario's population ages, the need for hearing health care services and trained professionals to provide those services will increase.

According to the World Health Organization, the main consequence of hearing impairment is an inability to understand speech in daily living conditions, which is considered a severe social handicap.[3] Hearing loss impacts communication, personal safety and quality of life and may indicate other illnesses or conditions. Untreated hearing loss may lead to more significant disability, and there is evidence that most hearing disorders are permanent and increase with aging.

---

[3] CASLPO, *Submission to HPRAC*, April 2005, pg 8

Assistive devices such as hearing aids, along with counselling and training in listening and communication can lessen the impact of hearing loss.

The Ontario Government recognizes the growing impact of hearing impairment and loss on its citizens. It has responded with programs to provide hearing assistance that include:

- Ontario's infant screening program which identifies and helps children who need hearing assistance. More and more children are being identified with hearing needs as a result of this program.
- The Assistive Devices Program (ADP) which approves audiologists and HIPs to dispense hearing aids within the program framework and helps offset the costs associated with hearing aid purchases.

A number of professional groups offer hearing health care and related services to consumers in Ontario, each according to their competencies and skill sets. Regulated health professionals authorized to provide hearing health care include family physicians, general practitioners, otolaryngologists, nurses and audiologists. Unregulated professionals providing hearing care services include hearing instrument practitioners such as hearing instrument specialists and hearing instrument dispensers, as well as communicative disorder assistants.

3.2 What is an Audiologist?

The *Audiology and Speech-Language Pathology Act, 1991 (ASLPA)* describes the scope of practice for audiology in Ontario: "The practice of audiology is the assessment of auditory function and the treatment and prevention of auditory dysfunction to develop, maintain, rehabilitate or augment auditory and communicative functions". Audiologists are concerned with the prevention, identification, assessment, treatment and rehabilitation of hearing difficulties in children and adults. They also provide education and counselling services for people experiencing hearing difficulties and vestibular problems, such as dizziness and tinnitus. Audiologists practice independently within their scope of practice.

Audiologists assess hearing, prescribe and fit hearing aids and other assistive listening devices and provide training for their use. Some audiologists also dispense hearing aids according to standards set by CASLPO. Audiologists may also offer hearing conservation programs to prevent hearing loss and public awareness initiatives to promote hearing health.

Where they work

There are approximately 470 audiologists in Ontario. They work in a variety of settings, including, but not limited to hospitals, public health units, community health centres, schools, private practice and industrial facilities. Some are also employed by hearing aid manufacturers. Others are employed in research or by post-secondary institutions where they develop and deliver academic curricula to future audiologists and students studying for various medical degrees.

As mentioned above, audiologists may be authorized to provide services under the Assistive Devices Program of the Ministry of Health and Long Term Care. Ontarians eligible for services under the program receive financial assistance toward the purchase of assistive devices.

Education and Training

Audiologists receive comprehensive post-baccalaureate training in non-medical hearing health care in university programs at the master's or doctoral level. Curricula include didactic and clinical placements to ensure audiologists have the competencies to prescribe hearing aids, verify and validate their performance, and counsel patients. Throughout their careers, audiologists are required by CASLPO to complete continuing educational programs to ensure their continuing competency.

3.3 What is a Hearing Instrument Practitioner?

Hearing instrument practitioners include hearing instrument specialists and hearing instrument dispensers. They are engaged in the testing of hearing and the selection, fitting, counselling and dispensing of hearing instruments pursuant to a prescription from a physician or audiologist.[6] The ADP indicates that the program relies on the services of 230 non-audiologist hearing instrument specialist authorizers and 413 non-audiologist hearing instrument dispensers.

Hearing Instrument Specialists do not assess hearing loss for infants or persons younger than 19 years of age, who represent about 10 percent of the hearing-impaired population. Under the ADP, an ENT doctor is required to assess first-time child applicants and any child applicants whose hearing loss is not stabilized. Upon clearance by the ENT doctor, HIPs may collaborate with physicians (and others) to co-manage patient needs. This includes providing services, such as ear mould impression taking or hearing aid fitting, for infants and children.

The primary client pool for hearing aid practitioners is the remaining 90 per cent of hearing impaired persons who suffer from either age-related or noise-induced sensorineural hearing loss[7], neither of which can be treated by surgical or medical intervention. Referral criteria jointly developed by the Ontario Medical Association (OMA) and AHIP, known as the red flag system, outlines the symptoms and conditions that require immediate referral to a physician. Following the referral, the physician may complete an assessment and may refer the patient to an ENT or audiologist for extensive assessment.

---

[6] AHIP, HPRAC Submission, June 2005, pg 3

[7] That is the same in both ears.

Education and Training

Hearing instrument specialist programs are offered through George Brown College and a new program at Conestoga College of Applied Arts and Technology.[*] The three-year diploma program prepares students to perform audiometric assessments required to select and dispense hearing aids and counsel patients. The course of study includes a practicum of about 400 hours under the direct supervision of a certified hearing instrument specialist. George Brown College produces some 20 to 30 graduates per year, and the new program at Conestoga College accepted 15 to 20 entry-level students in the 2005 and 2006 academic years.

Following graduation from community college, HIPs must complete the H.I.S. Internship Program which consists of a further 1,000 hours of practical and classroom instruction to qualify for AHIP membership.

Where they work

HIPs work independently in dispensaries in private practice or in settings such as community health centres, hospitals and long term care homes. Those who meet educational requirements and are AHIP members in good standing can be registered as non-audiologist authorizers and/or dispensers for the Ministry's Assistive Devices Program (ADP). Authorizer status permits them, according to a prescription, to test hearing impairment and identify and recommend hearing aids. HIPs also perform these services for Health Canada, Veterans Affairs Canada, Department of National Defence, Royal Canadian Mounted Police, Workplace Safety and Insurance Board and third party insurers.

3.4 What is a Speech Language Pathologist?

Speech language pathologists have specialized knowledge, skills and clinical training in the assessment and management of communication swallowing disorders. They are equipped to treat a broad range of speech, language, voice, swallowing and cognitive-communication impairments such as articulation problems, stuttering, voice and resonance disorders, cleft lips and palate, developmental language disorders, aphasia, traumatic brain injury and dementia among others. Impairments may be linked to developmental disorders or structural or functional causes. These may have developed over time, be part of a syndrome, or have resulted from cancers to the head and neck, stroke or head injury. The expertise of speech language pathologists includes assessment and treatment of:

- Language disorders to improve the ability to understand spoken and written language, convey ideas verbally and in writing, and communicate in social situations;

---

[*] The program was offered through Sheridan College from 1974 to 1988.

- Cognitive communications disorders to improve the reasoning, problem-solving, memory and organization skills required to communicate effectively;

- Speech disorders to improve articulation (pronunciation) and to help those who stutter improve their fluency;

- Swallowing disorders to ensure that clients are on safe diets and not at increased risk for choking or food or liquid build-up in the lungs.

Speech language pathologists also provide counselling to clients and caregivers on communication and swallowing disorders in relation to the client's abilities and challenges, and strategies to improve function and compensate for difficulties. They also consult with other professionals, such as audiologists, dieticians, nurses, occupational therapists, physicians, physiotherapists, social workers and teachers, to provide comprehensive programs of care. Others may pursue clinical and academic research into the processes underlying human communication or to explore the impact of various factors on communication leading to new treatment approaches.

Education and Training

Most practising speech language pathologists hold either a Master's of Science, or a Master's of Clinical Science – Communication Sciences and Disorders (Speech Language Pathology). Some may have qualified for their Ph.D. in the same field. To successfully qualify, applicants to the Master's programs have successfully completed a four-year undergraduate degree. Graduate programs include academic and clinical components. To be eligible for membership in the Canadian Association of Speech Language Pathologists and the Speech Language Pathologists of Ontario, 8-10 weeks of clinical experience must completed.

Where they work

Clients of all ages may receive services in a variety of health care, education and private settings.

3.5 How the Public Receives Hearing Health Care Services

Typically, the first stop for an individual experiencing hearing loss is the family physician or general practitioner. After an examination, the family physician or general practitioner will do one of three things:

1. Write a prescription and advise the patient to have it filled at the hearing aid dispensary of his or her choice, where the patient will be served by a hearing instrument practitioner or specialist.

2. Refer the patient to an otolaryngologist for a further specialized assessment or treatment in a hospital, community health care facility or private practice.

3. Refer the patient to an audiologist for further aural assessment. The audiologist may be located in private or group practice, in a hospital, a community facility or in mobile programs.

Consumer focus groups conducted for HPRAC verified that most Ontarians begin their experience with a family physician with fewer seeking initial care directly from audiologists.

Focus group respondents were often unclear whether care was provided by an audiologist or a hearing instrument practitioner. Several reported receiving similar tests from physicians and other professionals and being subject to what they felt were unnecessary referrals. This was seen as a costly duplication of service. More generally, they were confused about "who does what."

Once a prescription for a hearing aid has been provided to the consumer, he or she may choose to have it filled by either an audiologist or a hearing instrument practitioner, both of whom can dispense hearing devices.

3.6 The Association of Hearing Instrument Practitioners of Ontario (AHIP)

A voluntary not-for-profit association, AHIP represents 365 members who provide hearing health care services in more than 140 communities throughout Ontario. In the mid 1960's, the Ontario Hearing Aid Association was formed to create voluntary standards and regulations for the profession and, in 1983, the Association of Hearing Aid Dispensers was formed. In 1988, these associations merged to form what is now the Association of Hearing Instrument Practitioners of Ontario.[9]

AHIP's founding members established regulations and standards for members, and identified a need for formally trained professionals to practice in the field. This led to the establishment of hearing instrument specialist programs at the community college level to prepare students to perform audiometric assessments required to determine the selection of hearing aids, dispensing and counselling.

AHIP requires that entry-to-practice and qualification requirements are met by its members. This includes successful completion of formal education, mandatory continuing education and completion of a post-graduate internship. Members must also comply with the by-laws of the Association which contain a Code of Professional Conduct and include a formal mechanism to hear and resolve grievances.

While AHIP has made significant strides in voluntary self-regulation, all hearing instrument practitioners are not included in its membership, and it does not have a binding enforcement capacity.

---

[9] AHIP, HPRAC Submission, June 2005, pg 2

3.7 The Ontario Association of Speech Language Pathologists and Audiologists (OSLA)

Incorporated in 1965, OSLA is the voluntary, not-for-profit professional association for speech-language pathologists and audiologists in Ontario. It provides a range of services to its members, including professional support, inter and intraprofessional partnerships, dissemination of information and trends, research, access to resources, media relations, professional development, and public education. OSLA also cooperates with consumer groups and other stakeholders who depend upon the professional expertise of audiologists and speech-language pathologists. It is the advocacy organization for the two professions.[10]

3.8 Regulation of Hearing Health Professionals

A number of regulated and unregulated practitioners provide hearing health care and related services. Family physicians, general practitioners and otolaryngologists are members of the College of Physicians and Surgeons of Ontario (CPSO), and are authorized to prescribe a hearing aid and communicate a diagnosis. Nurses and nurse practitioners, who are regulated by the College of Nurses of Ontario (CNO), perform simple hearing screening tests on children and adults for the purpose of identifying hearing and or communication problems and referring for further assessment if necessary. Nurses also perform cerumen (ear wax) removal through the insertion of solution under pressure into the ear canal.

Audiologists are regulated under the College of Audiologists and Speech-Language Pathologists of Ontario (CASLPO) and under the current legislation, are authorized to prescribe a hearing aid for a hearing impaired person. Hearing instrument practitioners follow the voluntary self-regulation program of AHIP. Communication disorder assistants work under the supervision of a regulated professional.

4. The CASLPO Proposal

4.1 The Proposal

CASLPO's response to HPRAC recommends a three-tiered system of hearing health care encompassing the regulation of audiological assessment and hearing testing and new requirements for prescribing and dispensing hearing aids. As well, new restrictions on who can perform certain acts or services are proposed.

Controlled Acts

Under CASLPO's proposal:

- Prescribing a hearing aid would be defined to include the determination of the need for a hearing aid; determination of the specifications of a hearing aid, based on an audiological assessment (including testing and evaluation of the physical aspects of the ear); specifications of acoustic and physical parameters of a hearing aid; and that the prescription be validated. General prescriptions, such as those often provided by a family physician, would no longer be permitted.

---

[10] OSLA submission to HPRAC, June, 2005

- Several new controlled acts would be created including: audiological assessment and communicating the results; hearing testing; insertion of air, gas or water under pressure, application of energy, insertion of or removal of instruments, devices, fingers or other objects into or from the ear canal; cerumen (ear wax) management; dispensing hearing aids; and making an impression of the ear.

- Certain acts would be restricted to audiologists and physicians "with sufficient training and competence", and some acts would be restricted to regulated health professionals "who have the competencies". Other acts would be restricted to "persons who are not regulated and can demonstrate sufficient education, training and competence" and could be regulated by CASLPO.

Regulation

CASLPO proposes that:

- Any new regulated profession in the hearing health care sector should be regulated by CASLPO to ensure consistency in the regulation of all service providers.

- Hearing aid dispensaries should be controlled including standards of practice, physical aspects of the premises, equipment and business practices.[11]

Referrals and Qualifications

Audiologists are trained and educated to both prescribe and dispense hearing aids. However, if an audiologist wants to refer a patient to an ENT specialist, they must first refer to a general practitioner who then makes the referral to the specialist. This situation reportedly arises from the OHIP physician fee schedule and according to CASLPO creates additional costs and delays in the system. CASLPO's proposal asserts that audiologists should be able to refer directly to an ENT doctor.

The *RHPA* clearly recognizes audiologists as highly qualified hearing health care professionals. As such, consumers may, and do, question why audiologists are unable to make a direct referral to an ENT doctor. HPRAC notes that referral patterns between professional groups, and the effect this has on wait lists and patient health generally, is a topic for further consideration by MOHLTC.

---

[11] CASLPO Submission to HPRAC, April, 2005

4.2 Response to CASLPO's proposal

Respondents generally supported limiting the prescribing of hearing aids to physicians and audiologists. As well, respondents mostly supported both AHIP and CASLPO's view that hearing instrument practitioners should be regulated under the *RHPA*.

AHIP expressed concern respecting the structure of regulation proposed by CASLPO, and disputed the need to add hearing testing as a controlled act. AHIP notes that its members are fully qualified to independently perform several types of audiometric examinations, and points to the confidence in the competence of AHIP members shown by the Ontario Medical Association (OMA) and the ADP for consistently meeting their respective policy standards as proof of its members' abilities.

The College of Nurses of Ontario noted that increasing limitations on conducting hearing tests would impact the nursing scope of practice and could limit public access to initial screening. Further, the CNO said that nurses also perform cerumen (ear wax) removal through the insertion of solution under pressure into the ear canal, and making this a controlled act could affect the nursing scope of practice. The OMA indicated that, based on the evidence of harm, it was unnecessary to control the act of prescribing a hearing aid and further that any additional limitations on prescribing are unnecessary. The OMA further notes in its submission:

> CASLPO is recommending many new controlled acts be established and they be the sole practitioners authorized to carry out these new acts. This flies in the face of the intent of the *RHPA* regarding monopoly of the provision of services. The OMA believes that this reflects an attempt by audiologists to develop a monopoly where none is needed to protect the public from harm.[12]

5. Controlled Acts: Prescribing Hearing Aids

The Minister's question asks if the practice of general prescriptions for a hearing aid (i.e. determining the need) should give way to a regime of audiological testing and assessment (i.e. determining the specifications). The following factors have influenced HPRAC's recommendation that there should be no change to the controlled act of prescribing a hearing aid, and that the relevant colleges are capable of setting appropriate standards for their professions.

5.1 Risk of Harm

The conclusion reached in drafting the original *RHPA* legislation in 1991 was that risk of harm did not necessitate a detailed series of controlled acts for hearing health care. One controlled act (prescribing a hearing aid for a hearing impaired person), and a scope of practice for audiologists administered by a regulatory college, were considered sufficient protection for hearing health care consumers.

---

[12] Submission of the Ontario Medical Association to HPRAC, June, 2005

Since that time, CASLPO and OSLA have continued to question the difference in the way prescriptions are written by physicians and audiologists. Audiologists prepare a detailed specification of acoustic and physical parameters of a hearing aid based on an evaluation of auditory and communicative function, whereas physicians prepare a prescription based on hearing test results and other conclusions relating to the medical status of the patient. Audiologists do not make medical diagnoses, but rather make assessments based on the results of tests and communicative interventions with the patient. Under current legislation, audiologists are able to discuss the results of those assessments with the patient.

Evidence of Harm

The OMA conducted a search of scholarly work published during the period 1996 to 2004. Its review failed to find evidence of harm in the approach taken by physicians to prescribing. According to the OMA's submission:

> The concise Oxford dictionary defines the word "prescribe" as "advise the use of (a medicine, etc.)". The act of prescribing occurs not with the writing of words on a piece of paper but rather with the advising of a patient about the use of a medication or the item being prescribed, e.g., a hearing aid. When a physician prescribes a hearing aid based on hearing test results, the physician has ruled out the need for further medical treatment and has determined that the hearing aid will be of benefit to the patient. The patient is then referred to an audiologist or to a hearing instrument practitioner to obtain the device that will meet the patient's need and ability to pay.[13]

Audiologists, writing about evidence of harm, speak anecdotally of clients they have helped after an initial improper diagnosis or prescription.

> A nine year old girl came into my office [after having been tested] at an ENT's office about three years before…The mom had been told that her daughter's hearing was normal [so] mom had arranged speech [language therapy] for many years but there was no improvement noted. When she was seen by me, she had [severe hearing impairment], likely there from birth…This child went without intervention for years… because she was given the wrong information.[14]

For the elderly, improper diagnoses can be equally problematic as described by another practising audiologist.

> I recently saw an older woman with a moderately-severe hearing loss and poor dexterity wearing two… hearing aids. The amplification was only about 20 percent of what she truly needed. Her daughter almost

---

[13] OMA Submission to HPRAC, June 2005
[14] Submission by practicing audiologist to HPRAC

> cried when I told her this…For many years her mom had been reclusive. [Her family] had invested so much money…[and] thought these aids were…“state of the art.”[15]

CASLPO itself notes in its submission that “the evidence of physical harm arising from improper hearing aid prescription is inherently difficult to gather. However, it is widely accepted that, for infants [and children] with hearing loss, early audiologic intervention (which includes the appropriate prescription of hearing aids) is crucial to the development of speech and language…While a likely outcome of inappropriate prescription in such cases is a failure to reach one's communicative or academic potential, such consequences do not lend themselves to empirical scrutiny”.

Many of the examples of harm reported by audiologists relate more directly to quality of care issues.

HPRAC's own literature search of medical and audiological publications found no documentation of harm to consumers arising from current prescribing practices.

5.2 Access to Care

HPRAC concluded that placing parameters on the writing of prescriptions for hearing aids that are defined by audiology standards could have particularly negative consequences for access to hearing health care since it would *de facto* limit prescribing of hearing aids to audiologists. CASLPO's proposal to include audiological assessment and hearing testing as controlled acts would restrict the role of HIPs in hearing testing and may lead to waiting lists for service. The role of physicians in providing hearing aid prescriptions would be severely reduced.

The audiology program at the University of Western Ontario is the largest program in Canada, producing a maximum of 15 graduates per year, and sometimes far fewer.[16] Currently, there are 469 practising audiologists registered with CASLPO. With fewer than 500 audiologists in Ontario, this proposal would impact access to care for consumers throughout the entire province.

5.3 Accountability

Currently, family physicians, general practitioners, otolaryngologists and audiologists may prescribe hearing aids according to their professions' standards and their own professional judgment. Each is accountable to their college for making this determination and the college is accountable to the public for its supervision of individual professionals.

---

[15] Submission by practicing audiologist to HPRAC

[16] Letter from Ted Venema, PhD, Assistant Professor of Audiology, School of Communication Disorders, Elborn College, University of Western Ontario, 8 August 2005.

5.4 Conclusions relating to Prescribing Hearing Aids

In this matter, HPRAC concurs with the original conclusion of the Health Professions Legislative Review (HPLR), and of subsequent reviews. HPRAC believes that both the CPSO and CASLPO can set standards for delivering the controlled act of prescribing a hearing aid that are appropriate to their professions and ensure that their own members are competent to perform the act safely. However, it would be helpful for the two professions to consult each other regularly on improvement of standards and competency programs. HPRAC sees no merit in altering current provisions in the Act that could result in a significant loss of access to care for patients when there is no direct evidence that current practices are unsafe.

5.5 Recommendations

HPRAC recommends to the Minister:

1. That it is not necessary to further define the controlled act of "prescribing a hearing aid for a hearing impaired person" in section 27 (2) 10 of the *Regulated Health Professions Act, 1991*.

6.0 Controlled Acts: Other CASLPO Proposals

CASLPO recommended in its submission to HPRAC that additional controlled acts are required in hearing health care as follows:

The act and what's involved	Who can perform it
Audiological Assessment – Performing and communicating the results of an audiological assessment for the purposes of aural rehabilitation	Audiologists
Communicating an audiological diagnosis	Audiologists
Testing hearing	Audiologists and physicians other regulated health professionals who can demonstrate sufficient education, training and competence
Performing advanced diagnostic hearing test – Performing advanced diagnostic hearing tests on the general public, and on infants, children and difficult-to-test adults	Audiologists and physicians with sufficient training and competence
Insertions and removal – Insertion of air, gas, or water under pressure, or to apply energy in the form of high sound pressure levels, or to insert or remove instruments, devices, fingers or other objects into or from the ear canal	Audiologists and other regulated health professionals who are trained and competent to perform these specific procedures
Performing cerumen management	Audiologists and other regulated health professionals who have this specific competency

CASLPO also recommended that the Health Regulatory colleges that regulate and govern members involved in hearing testing should determine and recommend to the Minister the specific hearing tests to be controlled and the current regulated health professionals who should be authorized to perform them.

6.1 Legislative Intent

CASLPO's recommendations are controversial on a number of points. To a significant extent, the controlled acts proposed are procedures or aspects of a treatment plan that are better addressed through regulations, continuing competency requirements, standards of practice and clinical guidelines of a profession rather than as a controlled act under the *RHPA*. The Ontario Medical Association spoke to the intent of the legislation in its submission:

> The intent of the controlled act model was not to delineate and control each aspect of an assessment or procedure that may have some level of possible risk. For example, a surgical procedure has a very real element of risk, yet the controlled act is "performing a procedure on tissue below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, or in or below the surfaces of the teeth, including scaling of teeth." The regulated provider authorized to carry out this act does so as prescribed within the profession specific legislation. Each specific detail of the act is not spelled out, i.e., the controlled act of making an incision, etc.

6.2 Hearing Testing

Both the OMA and officials with the ADP told HPRAC that the end result of a highly regulated series of controlled acts in the delivery of hearing health services would restrict the number of hearing instrument practitioners in practice and thus limit consumer access and choice. AHIP submits that:

> In the absence of evidence that hearing testing is causing harm as it is currently practiced, and has been for many years, it should not be designated as a controlled act. In our opinion, including testing for hearing loss in the *RHPA* as a controlled act is an excessive measure. Consequently, Hearing Instrument Specialists should continue to be allowed to provide hearing testing in the future without the limitations envisioned by the CASLPO recommendation.

6.3 Cerumen management, inserting instruments, air gas or water under pressure

Most intervenors who commented on these aspects of treatment agreed that these procedures do not merit consideration as controlled acts. The College of Nurses noted that "Nurses also perform cerumen (ear wax) removal through the insertion of solution under pressure into the ear canal. Making this a controlled act could affect the nursing scope of practice."[17] The OMA said that "the removal of earwax from an individual's ear does not present a risk of harm for the patient. Physicians when dealing with young patients who may be frightened, or will not sit quietly for the procedure, may recommend that an ear syringing kit be purchased at the local pharmacy and the earwax removed while the child is taking his/her bath. Infection is likely not a concern."[18] AHIP told HPRAC that HIPs have been "safely providing these services for many decades without complaint or incident."[19]

6.4 Conclusions

HPRAC's review of the medical literature did not support making these procedures controlled acts. HPRAC concluded that appropriate standards for hearing testing and other procedures proposed should be established by the regulatory bodies concerned, whether CPSO, CASLPO or CNO. If there are substantial concerns about the risk of harm in these procedures, the respective colleges have the opportunity to address them through regulation or by seeking amendments to profession-specific acts that do not impinge on or restrict the scopes-of-practice of other professions. HPRAC is troubled by proposals which could further fragment hearing health care, create new silos and restrict other skilled practitioners from providing care. Controlled acts are the highest level of regulatory restriction under the *Regulated Health Professions Act, 1991*. Designating these procedures as controlled acts is not warranted.

6.5 Recommendation

HPRAC recommends to the Minister:

2. That audiological assessment and communicating the results; communicating an audiologic diagnosis; hearing testing; inserting air, gas, or water under pressure, applying energy in the form of high sound pressure levels, inserting or removing instruments, devices, fingers or other objects into or from the ear canal; or performing cerumen management should not be made controlled acts under the *Regulated Health Professions Act, 1991*.

7. Controlled Acts: Dispensing

The Minister asked for HPRAC's advice on what aspects of dispensing hearing aids should be controlled under the *RHPA*.

7.1 What is Dispensing?

Dispensing a hearing aid is the process of filling a prescription for a hearing aid. The dispensing process involves four steps:

---

[17] CNO Submission to HPRAC, June, 2005
[18] OMA Submission to HPRAC, June, 2005
[19] AHIP Submission to HPRAC, June, 2005

Audiometric testing – examples include: pure tone air and bone conduction thresholds; speech recognition thresholds; speech recognition score; tolerance/uncomfortable level; immitance; and masking, where necessary.[20]

Fitting – taking an impression of the ear and fitting the hearing aid appropriately to the individual.

Quality Control – ordering the product and ensuring that the manufactured product meets prescribed specifications and that the device performs as prescribed.

Patient Education – providing adequate information to care for and operate the hearing aid.

HPRAC reviewed several factors to determine whether the dispensing of hearing aids should be a controlled act under the *RHPA*.

7.2 Risk of Harm

In its submission, CASLPO draws attention to several known risks of harm associated with the dispensing process. Among the more serious are "perforation and/or removal of the tympanic membrane and/or ossicles, laceration of the ear canal and painful suction upon impression removal." The risk of harm is present where:

- Material could penetrate the perforation of the eardrum, filling the middle ear cavity and requiring surgical removal.
- Deep canal impressions are required for new completely-in-the-ear hearing aids. Deep canal impressions extend right up to the eardrum. This could lead to the possibility of bruised canal walls, soreness, irritation or damage to the eardrum.
- Injecting impression material could cause cerumen to become impacted against the eardrum requiring removal by a physician.[21]

CASLPO also noted there are other types of harm specific to dispensing, and which are specific to certain populations:

- In adults, physical harm to the external ear and/or ear canal or eardrum may occur when impressions are being taken for standard hearing aids. Following the fitting, physical harm to external ear and/or ear canal may occur from poorly shaped hearing aid(s). Adults face the hidden risk that they may not achieve the successful use of a device due to poor and or insufficient training.

---

[20] Ibid, pg 6
[21] CASLPO submission to HPRAC, April, 2005

- For children, serious pediatric harm may result from failure to counsel parents about dangers to infants from ingesting hearing aid batteries, resulting in exposure to toxic substances.
- The vulnerable elderly are at risk of diminished quality of life if they are persuaded to keep a hearing aid that is not providing benefit.

AHIP agrees that making an impression of the ear for the purpose of manufacturing a hearing aid can have an adverse outcome if performed by an unqualified person. Since 1993, AHIP members have faced seven liability actions. In each instance, the case involved improper application of ear moulds, one of the more important steps in the dispensing process.

7.3 Other Jurisdictions

HPRAC's jurisdictional review indicated that the dispensing, fitting (including ear moulds) and selling of hearing aids is regulated in British Columbia, Manitoba, Newfoundland, Nova Scotia, Saskatchewan, Quebec, Australia, New Zealand, United Kingdom, New York, California and Texas under various regulatory instruments.

7.4 Supervision

Currently, similar conditions exist among regulated professionals authorized to dispense (audiologists) and unregulated professionals (hearing instrument practitioners) who dispense hearing aids. Regulated and unregulated professionals work in similar settings, including private practice, community health centres, hospitals and long term care homes. Most often, they work independently, without supervision. Regulated and unregulated dispensers have comparable circumstances related to supervision and peer mentoring either in institutional settings or in private practice.

7.5 Consumer Protection

CASLPO raised issues relating to business practices in dispensing hearing aids that can disadvantage the consumer. These can include inappropriate processing of warranties or refusing to accept the return of a hearing aid that is not providing benefit. CASLPO also argues convincingly that the regulation of dispensing of hearing aids would result in standards of practice relating to advertising, conflict of interest and other competitive business practices that would enhance consumer protection.

HPRAC's consultation program, along with independent research, shows that consumers are confused about the roles played by different providers involved in their hearing health care. They may take false comfort in the assumption that all providers are regulated and must meet enforceable standards of practice and conduct. As the selling of hearing aids becomes increasingly competitive and large retail operations are engaged in the market, this issue is becoming more important to individuals and consumer groups.

7.6 Conclusions

HPRAC reviewed these positions, along with other evidence of the risk of harm, sufficiency of supervision and other matters determining whether a controlled act of dispensing is appropriate. The procedures and assessments involved in dispensing, most specifically related to ear moulds, can lead to patient harm unless performed by highly trained individuals. While it may be argued that this harm is not life threatening, the test does meet the other goals of the *RHPA*, including improving the quality of hearing health care and ensuring access to services.

7.7 Recommendation

HPRAC recommends to the Minister:

3. That Section 27 (2) 10. of the *Regulated Health Professions Act* should be repealed, and the following substituted:

    10. Prescribing or dispensing a hearing aid for a hearing impaired person.

8. Regulation of Hearing Instrument Practitioners

Having concluded that the dispensing of hearing aids should be a controlled act, HPRAC determined that it is logical to consider whether hearing instrument practitioners, who provide a significant portion of dispensing services, should be regulated under the *RHPA* in order to provide the controlled act services. HPRAC notes that AHIP, CASLPO, ADP, OMA and OSLA all recognize the special skills, training and competencies that HIPs bring to the table in hearing health, and there is broad agreement that hearing instrument practitioners should be brought under *RHPA* regulation. HPRAC examined practices in other Canadian, U.S. and international jurisdictions, and found that HIPs are licensed or regulated under a number of regulatory approaches.

8.1 Willingness to be Regulated

AHIP's June 2005 submission to HPRAC makes clear its interest in becoming regulated under the *RHPA* as a separate profession, with its own College. The Advisory Council also notes AHIP's efforts to set out educational requirements, practice standards, and codes of conduct for its members. HPRAC recognizes members' reportedly strong adherence to these requirements on a voluntary basis and sees this as indicative of members' willingness to respect the public interest as a regulated profession.

8.2 Access and Need

Hearing instrument practitioners who meet the educational requirements, and whose members are in good standing with AHIP, can be registered as non-audiologist authorizers and or dispensers for the ADP. Authorizer status permits them to test for hearing impairment as well as identify and recommend the most appropriate hearing aid for the individual in accordance with Ministry ADP policies and procedures.

The ADP submission to HPRAC states that both hearing instrument practitioners and audiologists are needed to meet Ontario's hearing health care needs. Its submission notes that 458 audiologist have registered as "authorizers" with the program. 321 audiologists are also approved by the ADP to dispense. Some audiologists are registered in both categories. Similarly, 230 hearing instrument specialists have been approved to authorize hearing aids under the program. 413 hearing instrument dispensers are registered.

The ADP submission notes that restricting either group's roles would severely impact access to services for clients as well as client choice.[22]

8.3 Accountability

Despite AHIP's commendable steps to govern its members, it does not have the authority to ensure that members meet the voluntary standards it has established. The Association could also be considered to be in a conflict position – that of both representing and governing its membership. An important protection under the *RHPA* is that there is a clear distinction between the association that advocates on behalf of the profession and the regulatory college that governs the profession in the public interest.

A great deal of reliance is placed on the "red flag" referral system used by HIPs to send clients to physicians for follow-up treatment but the association has no legal mechanism to ensure that this standard, or any other that it sets, is followed.

Some argue that the possibility of being removed from the ADP list of registered service providers is an incentive for members to abide by AHIP's standards and continuing education requirements. However, the ADP's role is to fund the provision of hearing aids, and not to enforce standards. It does not focus on professional regulation in the public interest.

8.4 Regulatory Safeguards

Addressing the 'regulatory patchwork'

Physicians, nurses and audiologists are members of regulatory colleges that provide an accessible complaints process for patients and that incorporates the consumers' perspective in its governing structure through publicly-appointed members of each college council. Hearing instrument practitioners are unregulated, and while AHIP has done considerable work to set standards and establish a complaints process as a voluntary self-regulating organization, its procedures do not have regulatory authority nor requirements for public accountability. Nonetheless, HIPs provide many of the same dispensing services as audiologists, share some of the audiology scope-of-practice, and provide hearing care to a significant number of Ontarians.

---

[22] ADP Submission to HPRAC, 17 June 2005, pg 2

Quality Assurance Required

The *RHPA* requires that each regulated profession has a mandatory quality assurance program. Given the dramatic changes in technology and health knowledge, all hearing health professionals should be subject to and benefit from quality improvement requirements. AHIP has made steps in this area, but a regulated college model provides more rigour to these activities and raises the bar on educational requirements as technological and scientific knowledge advances.

8.5 Public and Practitioner Confusion

The current system creates considerable public confusion over who provides what service. Consumers invited to participate in HPRAC's consultations were often unable to identify or distinguish whether the professional providing their care was an audiologist or a hearing instrument practitioner. However, consumers were clear that they expected those providing service should be required to meet the highest standards. Consumers often thought that all professionals providing the same services were regulated.

Some consumers reported incidents of being referred back and forth between hearing health professionals and of being subjected to the same hearing tests on multiple occasions. This was criticized as unnecessary and costly duplication.

HPRAC heard that there is also a lack of shared knowledge between audiologists and HIPs about their respective professional standards for treatment, referral and follow-up care, and that there were few efforts to work together on continuing competence or to provide peer support and mentoring.

8.6 Conclusion

Including hearing aid practitioners in the *RHPA* model is consistent with Ontario's approach to health regulation, and would provide the public accountability required of a self-regulating profession. Regulation would set minimum qualifications for entry-to-practice, complaints and discipline processes, quality and continuing competence requirements, and discernable practice standards for hearing instrument practitioners. HPRAC's recommendation that dispensing a hearing aid be recognized as a controlled act is logically followed by the regulation of hearing instrument practitioners who, along with audiologists, provide a significant amount of dispensing services in Ontario.

8.7 Recommendation

HPRAC recommends to the Minister:

4. That hearing instrument practitioners should be regulated as a profession under the *Regulated Health Professions Act, 1991.*

9. Options for Regulation

Having concluded that HIPs should be regulated under the *RHPA*, HPRAC considered a number of options for regulation and other matters associated with regulation.

Regulatory Models

HPRAC analyzed a number of regulatory models that might be used to accommodate the regulation of hearing instrument practitioners and, at the same time, reflect the reality of overlapping scopes-of-practice between hearing instrument practitioners and audiologists. The Advisory Council's goal is that the model selected will enhance multidisciplinary collaboration and provide opportunities for joint quality programs and common development of standards of practice when there are shared procedures between two professions.

Options considered by HPRAC included:

9.1 Stand-alone College

In its submission to HPRAC, AHIP proposes that hearing instrument practitioners should be regulated in an independent college under the *RHPA*. AHIP is concerned that regulation in the College of Audiologists and Speech Language Pathologists would seriously compromise the status of HIPs "as an integral part of the hearing health care team given the existing misconceptions regarding …qualifications and competencies".[23]

HPRAC reviewed this option, noted the willingness of the profession to be regulated and the likelihood that its members would comply with the demands of regulation under the *RHPA*. HPRAC was concerned, however, about the heavy burden that would be placed on the 365 existing AHIP members in establishing and supporting a stand-alone college, whose mandate is to protect the public interest, while at the same time maintaining an active association that advocates on behalf of the profession.

HPRAC also fears that a stand-alone college would entrench professional misunderstandings between audiologists and hearing instrument practitioners and would soon result in competing standards. Health care is increasingly provided through multi-disciplinary teams, and it would be counterproductive to create a regulatory scheme that does not support a collaborative approach. HPRAC is convinced that there should be less, rather than more, fragmentation of related health professions. This was not seen as a viable option.

9.2 Regulation under CASLPO

An option would be for HIPs to become registered as members of CASLPO. AHIP has expressed clear reservations about this alternative, believing that its members would be disadvantaged.

---

[23] AHIP submission to HPRAC, June 2005

HPRAC recognizes that a lack of mutual knowledge concerning competencies of both professions has led to misconceptions and mistrust on the part of both professional associations and others. Simply extending CASLPO's authority over HIPs would not be acceptable to practitioners or to key stakeholders. This was, therefore, not seen as a preferred option.

9.3 A New Composite College

HPRAC considered the option of winding down CASLPO and creating a new college of speech language pathologists, audiologists and hearing instrument practitioners. This option would create an opportunity for speech language pathologists, audiologists and HIPs to address regulatory gaps and to work together to resolve issues and improve future practice. With three professions involved, it would provide a clear signal to other professionals of the benefits of collaboration while continuing to independently establish qualifications and practice standards. The disadvantage of this proposal is that existing functions of CASLPO would be disrupted in a transition, and the process would be cumbersome for current members of the College. As a result, HPRAC concluded that this was not a preferred option.

9.4 Preferred Option: A Hybrid Composite College

HPRAC's recommended option is to establish a new College of Hearing and Speech-Language Professionals of Ontario using the framework of the existing College of Audiologists and Speech Language Pathologists. The important regulatory functions of CASLPO would continue while a new college is established.

The new college would recognize each profession through the election of members to the council, and by inclusion of members of the profession in complaints, discipline or fitness-to-practice proceedings when a member of the profession is involved.

As well, new provisions in the legislation would enable the council to establish special-purpose committees to address profession-specific matters concerning the development and review of standards of practice and continuing competence, quality assurance and quality improvement programs within the profession. Council would also have the ability to strike special purpose committees to consider inter-disciplinary issues, for example, where scopes and standards of practice have common ground. The college would be charged with advancing inter-disciplinary cooperation and ensuring that all registered members are able to function to the maximum extent of their training and skills.

Neither the scope-of-practice of audiology nor that of speech-language pathology would change. A new scope-of-practice for hearing instrument practitioners would be introduced. Audiologists would continue to be authorized to prescribe hearing aids, and along with hearing instrument practitioners, would be additionally authorized to perform the new controlled act of dispensing hearing aids.

In HPRAC's view, audiologists and hearing instrument practitioners are both capable of dispensing hearing aids without supervision. If both professions are included in a common regulatory scheme, it will be possible to establish standards of practice to ensure, for instance, that hearing tests for children under 19 years are performed only by an audiologist, and to develop practice standards relating to ear moulds or other common procedures necessary to dispensing. The professions would have the opportunity to develop standards and guidelines that are unique to their professions within the college, including those relating to hearing testing or business practices. Similarly, speech language pathologists would be able to consider standards of practice unique to their profession in a special purpose committee, or to work in conjunction with one or both of the other professions when there are matters of common interest.

CASLPO has identified several areas that require attention in the dispensing of hearing aids. These are infection control practices for ear impressions and fittings, conflicts of interest, consumer protection, and the use and maintenance of testing equipment. These issues could be addressed through collaborative discussions and adoption of best practices.

In the event of a dispute between the professions relating to standards, the college council including members appointed by the Lieutenant-Governor-in-Council, would be the arbiter. The council would also be responsible for confirming regulations, standards, guidelines and rules (as is now the case for all colleges) as a matter of practice or as required by the *RHPA*.

9.5 Conclusion

Including hearing instrument practitioners with audiologists and speech-language pathologists within a revitalized *RHPA* college, and adding one additional controlled act, is an effective and efficient mechanism for improving the regulation of hearing health care professionals. It provides safeguards for the public without limiting consumer access to care. It also sets the stage for a better understanding among hearing and speech-language professionals, and should foster collaboration.

10. Transition

Transitional Council

To ensure a smooth implementation, HPRAC recommends that a transitional council be established to lead to a new college, and that it should include: two representatives nominated by AHIP; two members of CASLPO's Council including at least one audiologist; an academic representative; and individuals appointed by the Lieutenant-Governor-in-Council. The council could establish sub-committees to assist with its work, and would have the following functions:

- Develop a list of practitioners who identify themselves as hearing instrument practitioners.
- Identify a core body of knowledge common to hearing instrument practitioners.
- Develop educational qualifications and equivalencies for registration.
- Direct the registrar to register those applicants who meet the qualifications for registration, and identify any terms, limits or conditions that should attach to the registration of an applicant.

- Establish standards of practice for hearing instrument practitioners.
- Develop quality programs for hearing instrument practitioners.
- Develop communications programs to provide information to hearing instrument practitioners, academic institutions, other professions and members of the public.

The College of Audiologists and Speech Language Pathologists of Ontario would continue until the new College is established. HPRAC estimates that the work of the Transitional Council could be completed in a maximum of two years.

11. Recommendations

HPRAC recommends to the Minister:

1. That it is not necessary to further define the controlled act of "prescribing a hearing aid for a hearing impaired person" in section 27 (2) 10 of the *Regulated Health Professions Act, 1991*.

2. That audiological assessment and communicating the results; communicating an audiologic diagnosis; hearing testing; inserting air, gas, or water under pressure, applying energy in the form of high sound pressure levels, inserting or removing instruments, devices fingers or other objects into or from the ear canal; or performing cerumen management should not be made controlled acts under the *Regulated Health Professions Act, 1991*.

3. That Section 27 (2) 10. of the *Regulated Health Professions Act* should be repealed, and the following substituted:

   10. Prescribing or dispensing a hearing aid for a hearing impaired person.

4. That hearing instrument practitioners should be regulated as a profession under the *Regulated Health Professions Act, 1991*.

5. That the name of the *Audiology and Speech-Language Pathology Act, 1991* should be changed to the "Hearing and Speech-Language Professionals Act".

6. That the definition of "College" in Section 1 and Section 2 (2) of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed, and the following substituted:

   "College" means the College of Hearing and Speech-Language Professionals of Ontario ("ordre")

7. That the definition of "profession" in Section 1 and Section 2 (2) of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

   "profession" means the professions of audiology, speech-language pathology and hearing instrument practitioners

8. That a new definition of "by-laws" should be added to Section 2 (2) of the *Audiology and Speech-Language Pathology Act, 1991* as follows:

    "by-laws" means the by-laws under this Act.

9. That Section 3 of the *Audiology and Speech-Language Pathology Act, 1991* should be amended by adding the following subsection:

    The practice of hearing instrument practitioners is the testing of hearing and the fitting and dispensing of hearing aids.

10. That Section 4 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed, and the following substituted:

    (1) In the course of engaging in the practice of audiology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to prescribe or dispense a hearing aid for a hearing impaired person.

    (2) In the course of engaging in hearing instrument practice, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense a hearing aid for a hearing impaired person.

11. That Section 5 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    The College is established under the name College of Hearing and Speech-Language Professionals of Ontario in English and Ordre des professionnels de l'audition et de l'orthophonie de l'Ontario in French.

12. That Section 6 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) The Council shall be composed of,

        (a) at least eight and no more than nine persons who are members elected in accordance with the by-laws;
        (b) at least six and no more than seven persons appointed by the Lieutenant-Governor-in-Council who are not,
            (i) members,
            (ii) members of a College as defined in the *Regulated Health Professions Act, 1991*, or
            (iii) members of a Council as defined in the *Regulated Health Professions Act, 1991*; and
        (c) three persons selected, in accordance with a by-law made under section 11, from among members who are members of a faculty of audiology or speech-language pathology of a university in Ontario or of a hearing instrument specialist program of a community college in Ontario.

Who can vote in elections

(2) Subject to the by-laws, every member who practises or resides in Ontario and who is not in default of payment of the annual membership fee is entitled to vote in an election of members of the Council.

13. That Section 8 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) No person other than a member shall use the titles "audiologist", "speech-language pathologist", "speech therapist", "hearing instrument practitioner" or "hearing instrument specialist", a variation or abbreviation or an equivalent in another language.

    Representations of qualification

    (2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an audiologist, a hearing instrument practitioner, a hearing instrument specialist or a speech-language pathologist or in a specialty of audiology, speech-language pathology or a hearing instrument practice.

    Definition

    (3) In this section
    "abbreviation" includes an abbreviation of a variation.

14. That Section 11 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) The Council may make by-laws respecting the qualifications, selection and terms of office of Council members who are selected.

    (2) The by-laws shall provide for equal representation of audiologists, speech language pathologists and hearing instrument practitioners.

    (3) The Council shall make by-laws establishing three committees, each committee to be composed exclusively of members of one profession and lay members with the authority, subject to approval by Council, to establish rules, standards of practice and guidelines on matters of exclusive application to that profession in accordance with subject matter and criteria established by Council.

15. That Section 12 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) The College of Audiologists and Speech Language Pathologists of Ontario shall continue in force until section 5 is proclaimed.

    (2) The Lieutenant-Governor-in-Council, on recommendation of the Minister of Health and Long-Term Care, shall appoint for a period of two years, a Transitional Council, a Chair and Vice-Chair.

(3) The Transitional Council shall be composed of a Chair; a Vice-Chair; at least two representatives nominated by the Council of the College of Audiologists and Speech-Language Pathologists; at least two representatives nominated by the Association of Hearing Instrument Practitioners; one representative of a faculty of a hearing instrument specialist program of a community college in Ontario, and at least three and no more than four persons who are not members of the College of Audiologists and Speech-Language Pathologists.

Powers of Transitional Council

(4) After (date) but before this Act comes into force, the Transitional Council and its employees and committees may do anything that is necessary or advisable for the coming into force of this Act and that the Council and its employees and committees could do under this Act if it were in force.

Idem

(5) Without limiting the generality of subsection (3) the Transitional Council may appoint a Registrar and the Registrar and the Council's committees may accept and process applications for the issue of certificates of registration, charge application fees, and issue certificates of registration.

(6) Upon appointment of its members, the Transitional Council shall move immediately to:

1. Develop a list of practitioners who identify themselves as hearing instrument practitioners (including dispensers and specialists).
2. Identify a core body of knowledge common to hearing instrument practitioners.
3. Develop educational qualifications and equivalencies for registration.
4. Direct the registrar to register those applicants who meet the qualifications for registration, and identify any terms, limits or conditions that should be attached to the registration of an applicant.
5. Establish standards of practice for hearing instrument practitioners.
6. Develop quality programs for hearing instrument practitioners.
7. Develop communications programs to provide information to hearing instrument practitioners, academic institutions, other professions and members of the public.

Powers of Minister

(7) The Minister may:

(a) review the Transitional Council's activities and require the Transitional Council to provide reports and information.

(b) require the Transitional Council to make, amend or revoke a regulation under this Act.

(c) require the Transitional Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act and the *Regulated Health Professions Act, 1991*.

Transitional Council to comply with Minister's request

(8) If the Minister requires the Transitional Council to do anything under subsection (7), the Transitional Council shall, within the time and in the manner specified by the Minister, comply with the requirement and submit a report.

Regulations

(9) If the Minister requires the Transitional Council to make, amend or revoke a regulation under clause (7) (b) and the Transitional Council does not do so within sixty days, the Lieutenant-Governor-in-Council may make, amend or revoke the regulation.

Idem

(10) Subsection (8) does not give the Lieutenant-Governor-in-Council authority to do anything that the Transitional Council does not have authority to do.

Expenses

(11) The Minister may pay the Transitional Council for expenses incurred in complying with a requirement under subsection (6).

12. Additional Issues for Consideration

12.1 Quality of Care

While the public consultations produced a small number of anecdotes relating to improper care, inappropriate diagnosis, or hearing aids left unused "hearing aids in drawers", overall, the consensus was that the quality of hearing health care in Ontario was above average.

A notable exception was hearing health care for senior citizens in long-term-care homes. Several reports from consumers and professionals alike recounted how seemingly disengaged seniors reconnected with their surroundings once ear wax was removed from their hearing aids. This is a delivery issue rather than a professional regulation matter, but HPRAC suggests that it be taken into account in planning services for seniors through home care or long-term-care programs.

12.2 Professional Titles

OSLA and many audiologists made strong representations to HPRAC that professionals who had earned an academic doctorate should be entitled to use the doctor title in the course of providing health care. HPRAC is recommending expansion of the use of the doctor title, and this matter is further discussed in the Legislative Framework section (Chapter 2) of this report.

REGULATION OF OPTICIANS

The Minister's Question

Concerning the practice of opticianry, in February, 2005 the Minister of Health and Long-Term Care requested advice from the Health Professions Regulatory Advisory Council (HPRAC) as to whether:

> there is a risk of harm in dispensing eye wear and what aspects, if any, of this activity need to be controlled by the [*Regulated Health Professions Act, 1991*] *RHPA*, whether refractometry is within the scope of practice of opticianry, and how standards should be set and measured for both of these activities.[1]

HPRAC approached this request in two parts.

1) Dispensing Eye Wear
HPRAC considered whether there is risk of harm associated with the act of dispensing eye wear; and if dispensing eye wear should continue to be a controlled act under the *RHPA*.

2) Refractometry
HPRAC examined whether refractometry is currently within the scope of practice of opticianry; and whether refractometry should be in the scope of practice of opticianry.

These questions needed to be addressed before the questions of standards could be examined.

HPRAC's Response

HPRAC recommends that dispensing prescription eye wear should continue to be a controlled act under the *RHPA*.

On the question of refractometry, HPRAC recommends that qualified opticians should be authorized to conduct refraction tests in those circumstances where such refracting is undertaken in collaboration with an optometrist or a physician for the purpose of informing a comprehensive ocular assessment.

1. The Consultation Process

HPRAC invited submissions and initiated consultations with a broad group of stakeholders. HPRAC reviewed 28 stakeholder submissions, including documents submitted by the College of Opticians of Ontario (COO) and the Ontario Opticians Association. Fourteen additional interviews were conducted with interested colleges and associations.

---

[1] Minister's Referral Letter, February 2005, Appendix A

Members of the public were asked to participate in focus groups. These groups were supplemented by a number of telephone interviews. Consultations examined all aspects of the Minister's referral.[2] In addition, literature and jurisdictional reviews were undertaken, and clarifications sought from other jurisdictions.

2. Background

2.1 How the Public Receives Eye Care

In Ontario, eye care services are provided by members of regulated health professions, including opticians, optometrists, ophthalmologists, general practitioners and family physicians. Each profession has a scope of practice related to eye care services which defines the range and type of services they can provide. The steps involved in the process through which people obtain prescription eye wear include:

- patient assessment (ocular examination);
- communicating a diagnosis
- writing a prescription for eye wear;
- dispensing eye wear based on the prescription.

There is some overlap in scopes of practice amongst eye care professionals. For instance, ophthalmologists and optometrists can complete a vision test and prescribe eye wear. Opticians and optometrists can dispense eye wear.

2.2 What is an Optician?

The process through which eye wear prescriptions are filled is called dispensing. Opticians dispense eye wear to the public based on a prescription from an optometrist or physician. Optometrists also have the authority to dispense eye wear. Eye wear includes eye glasses other than simple magnifiers, contact lenses and subnormal vision devices. In addition to dispensing, opticians also provide advice on the suitability of frames or contact lenses. By taking into account the physical characteristics and individual circumstances of a client, such as occupation and activities of daily living, opticians help customers identify the most appropriate type of eye wear.

The majority of opticians practice in easily accessible retail environments and are often asked about eye-related concerns. In their role as front-line eye care professionals, opticians must refer people with complex eye conditions to a general practitioner, optometrist or ophthalmologist.

There are approximately 2,000 opticians practicing in Ontario. The majority are located in urban areas. Almost one-quarter of opticians practice in the city of Toronto. On average, 35 new registrants are added each year to Ontario's pool of practicing opticians.

---

[2] Submissions are posted on the HPRAC website, www.hprac.org

2.3 Education and Training

Opticians are required to complete a two-year, full-time opticianry diploma program approved by the Ministry of Training, Colleges and Universities, or an equivalent program approved by the Registration Committee of the College of Opticians of Ontario. In Ontario, Seneca and Georgian colleges offer diploma programs in opticianry. Course curricula include dispensing and refractometry.

- ***Dispensing*** – As part of their training, opticians complete a practicum of at least 1,000 hours in a dispensary under the supervision of an optician, optometrist or physician. During this practicum, students must dispense at least 250 eye glasses and 20 pairs of contact lenses to ensure that their skills are adequate.
- ***Refractometry*** – Also known as automated sight testing, refractometry is the act of measuring the refractive error of the eye for the purpose of a sight test. It, too, is taught at Seneca and Georgian colleges. In the past, refractometry was a manual painstaking procedure. Today, it is largely a mechanized process. From an eye health perspective, it forms only one part of an eye exam. Competencies for refractometry have been incorporated into the National Accreditation Committee of Opticians Competency Matrix. These competencies were developed by the National Association of Canadian Optician Regulators (NACOR).

2.4 The College of Opticians of Ontario

The Opticianry Act, 1991, established The College of Opticians of Ontario (COO) as the self-governing body for the profession. The COO is responsible for registering and regulating opticians, and for maintaining the practice standards and skill proficiencies of its members through quality of care and education programs. Standards of practice and continuing competence programs help ensure that practitioners are qualified to perform the controlled act authorized for the profession. They also impose accountability on the performance and conduct of practitioners.

2.5 Other Jurisdictions

The opticianry profession is regulated in all Canadian jurisdictions except for the Northwest and Yukon Territories. Within all of the regulated jurisdictions, the act of dispensing is reserved or controlled by legislation. Opticians are entitled to dispense eyewear based on an optical prescription prepared by a qualified professional.

In seven of the regulated jurisdictions (BC, Alberta, Saskatchewan, New Brunswick, PEI, Nova Scotia and Newfoundland and Labrador) the licensing of opticians is divided into two categories based on the ability to dispense contact lenses. In jurisdictions without the split licensing, such as Ontario, contact lens training is incorporated into all optician education programs.

In the United States, the regulation of health professionals is controlled by each state independently. As of October 2004, 24 states license/regulate opticians. 27 states do not feel a significant risk of harm exists to warrant the licensing, certification or registration of opticians. Many states prohibit independent opticians from dispensing contact lenses, effectively tying the sale of contact lenses to ophthalmologists and optometrists.

3. Dispensing Prescription Eyewear

3.1 The Dispensing Process

There are four steps in the dispensing process.

- ***Preparation:*** Professional applies their knowledge of eye wear to determine the most appropriate lens and or frame for the individual based on a prescription, determines the viability of a lens according to the prescription and measures the client's face correctly.

- ***Adaptation:*** Sometimes it is necessary to adapt the power of the lens based on the fit of the eye wear and the physical attributes of the individual. This requires professional judgment to avoid errors that affect the overall effectiveness of the eye wear.

- ***Verification:*** The professional serves as a quality check-point and verifies the accuracy of the manufacturing process. Because the manufacturing process is unregulated, accountability for the quality of the eye wear resides with the professional.

- ***Delivery:*** Ensuring the proper fit of eye wear and adjustment of eye glasses are an important part of delivery. So, too, are patient education and follow-up care instructions. The health of the individual's eye may depend on the clarity and accuracy of these instructions.

3.2 Relevant Safeguards

Controlled Acts

1. *Prescribing* – Only physicians and optometrists are currently authorized to prescribe eye wear. Requiring a prescription for eye wear ensures that changes in sight are monitored by a professional who can diagnose the cause of any impairment to eyesight in conjunction with other health conditions.[1]

2. *Dispensing* – The act of dispensing eye wear has been controlled under legislation since the inception of the opticianry profession, and was affirmed in 1991 during the creation of the *RHPA*.

---

[1] Simple magnifiers (such as the eyeglasses one may see in a drug store) are not classified as eye wear, and may be purchased over the counter.

Dispensing prescription eye wear is controlled to reduce the risk of harm associated with the preparation of complex prescriptions. The current legislation allows both opticians and optometrists to dispense eye wear. Both professions are accountable for the accuracy and quality of the product they dispense.

Standards of Practice for Dispensing

The regulatory colleges for opticianry and optometry have both established standards of practice for dispensing eye wear. In addition, both have statutory complaints, discipline and quality assurance committees and processes to consider breaches of professional standards, and to improve the competence of members of the profession.

4. Factors Informing HPRAC's Recommendation

4.1 Risk of Harm

There is consensus among practitioners and in published literature that there is a risk of harm to patients and clients in dispensing prescription eye wear. An Ontario court judge recently upheld that sufficient evidence exists, beyond a reasonable doubt, to establish risk of harm in dispensing.[1] The extent of the risk, however, is uneven.

Risks vary by type of eye wear, age and or condition of the patient, complexity of the prescription and the skill of the dispensing practitioner. Examples of areas where risk of harm is significant include:

- ***Dispensing Contact Lenses*** – As lenses are in direct contact with the eye, wearers face an increased threat of allergic reactions, infection (leading to corneal scarring), corneal edema (swelling), and corneal abrasion (due to poor lens fit). All can result in permanent impairment. Wearers also risk permanent damage in instances where lenses block oxygen from reaching the inner areas of the eye. Patient education provided during the dispensing process can mitigate these risks.
- ***Dispensing Eye Wear to Children Under 19 Years*** – One of the most common eye disorders in children is Amblyopia, often referred to as "lazy" or "wandering" eye. Early treatment, including patch therapy, surgery and prescription glasses, can correct many childhood vision impairments. Health Canada considers patients under the age of 19 to be receptive to corrective treatments. For children requiring corrective eye wear, the accuracy of the dispensed eye wear directly influences the effectiveness of the treatment. As well, it is important to ensure that children receive eye glasses with lenses that do not shatter.

---

[1] College of Opticians of Ontario v. Sandra Wadden and King Optical Group Inc. (1999) Ontario Court of Justice.

- ***Dispensing Eye Wear to Adults Over 65 Years*** – Age-related eye diseases, such as macular degeneration, cataracts, diabetic retinopathy and glaucoma complicate the eye wear needs of many older patients and require monitoring by a skilled professional. These and other vision impairments can have substantial adverse effects on quality of life among the elderly. Commonly, seniors rely on multifocal glasses to correct for age-related presbyopia – the reduced ability to focus on close objects. However, because the lower lenses of multi-focal glasses blur floor-level objects, the risk of falling is increased. To minimize this risk, an accurate fit is important.

- ***Dispensing Low Vision Aides*** – Low vision aides are used to improve the vision of individuals coping with extreme visual impairments. Vision aides include telescopes, prescription reading glasses, large-print reading materials, magnifying aides, closed-circuit televisions, audio tapes, electronic reading machines and computers that use large print and speech. The risk of harm associated with dispensing low vision aides is related to patients' dependence on vision aids for daily living. Errors made in the dispensing of low vision aids may directly contribute to accidents among patients.

- ***Dispensing Complex Prescription Eye Wear*** – Prescriptions for eye wear can be complex. Bifocals, progressive lenses and high correction factors require skill to ensure that crucial elements of the prescription are interpreted and fabricated correctly. Errors in manufacturing and dispensing based on these prescriptions will be readily apparent to patients, as their vision will not be fully corrected.

It is less clear that there is a significant case for risk of harm for healthy adults aged 19-64. Evidence shows that risks for healthy individuals in these age groups may be minimal.

4.2 Two-Tier Regulation

Risk of harm exists for young people and seniors, and for individuals using contact lenses, low vision aides or complex prescription eye wear, regardless of age. The risk of harm for others may be minimal. With this in mind, HPRAC considered the merit of deregulating prescription eye wear dispensing for a subset of the population, specifically those aged 19-64. HPRAC concluded that this decision would not be optimal for the following reasons:

1. Regulating dispensing for only a subset of prescriptions would result in a tiered system where unregulated individuals would dispense a subset of eye wear to a subset of the population. The dispensing of eye wear for those younger than 19 and older than 64, as well as the dispensing of contact lenses and low vision aides would still require regulation. The situation could be difficult to implement and monitor.

2. Currently, the optician or optometrist verifies the prescription of the eye wear before delivering it to the client. Deregulating dispensing for certain types of eye wear compromises the quality and dependability of the dispensing service as a whole.

3. Consumer understanding of the respective roles of opticians, optometrists and ophthalmologists is limited but their expectations are not. Deregulating the dispensing of eye wear would expose consumers to yet another provider, the unregulated dispenser. The potential for misunderstanding would be significant. Patient safety could be compromised.

4. Because the annual eye exam for the general population aged 19-64 is no longer insured under OHIP, it becomes all the more important for this group to have a trained professional dispense eye wear to them so that an appropriate referral can be made if necessary.

4.3 Public Interest

Focus groups demonstrated that people expect an individual dispensing eye wear to be properly trained, and that standards for dispensing be applied and monitored. Current legislation holds the professional accountable for the accuracy and quality of dispensed eye wear. Deregulation of dispensing would reduce accountability, and could lead to a reduction in quality of care and patient safety.

5. Recommendation

The Advisory Council concludes that there is a risk of harm to the public in dispensing prescription eye wear. Although the risk is variable, HPRAC recommends that all aspects of dispensing prescription eye wear remain controlled. Specific aspects of dispensing that need to be controlled are: preparation, adaptation, verification, and delivery.

As well, HPRAC concludes that the current regulatory framework for dispensing prescription eye wear serves the public interest. Therefore, HPRAC recommends:

That dispensing subnormal vision devices, contact lenses, or eye glasses other than simple magnifiers should remain a controlled act under the *RHPA*.

6. Delegation

Under the *RHPA*, regulated health care professionals can delegate any of their controlled acts without restriction. The recipient of such delegation may or may not be a member of the regulated profession. A College can set conditions, limitations or restrictions, or can prohibit their members both from delegating and receiving delegations. Once a controlled act has been delegated, the member delegating the act remains responsible and is accountable to the patient. This member has an ongoing duty to supervise.

HPRAC has noted inconsistencies between the delegation policies of colleges whose members provide eye care. The provision for delegation of controlled acts in the *RHPA*, combined with professional misconduct regulations under the *Optometry Act*, allows optometrists to delegate the controlled acts authorized to optometry, as well as to receive delegation of controlled acts not otherwise authorized to optometry. On January 13, 2005, the council of the College of Optometrists of Ontario approved a new policy on delegation and assignment that places appropriate safeguards on the giving and receiving of delegation by members.[5] Medicine has established guidelines for delegation, with the reminder to physicians that the responsibility for delegation remains with the delegating physician.

The College of Opticians, on the other hand, prohibits members from delegating all or part of the controlled act that is authorized to opticians.[6] The regulation further prescribes acts of professional misconduct to include:

> 5.1 Permitting, counselling or assisting a registered student optician or a registered intern optician to dispense subnormal vision devices, contact lenses or eye glasses, except under the supervision or direction of a registered optician who is physically present in the place where the dispensing takes place, at the time it takes place.

Evidence shows that the risk of harm in dispensing non-complex eye wear for people aged 19-64 is minimal. Where a significant risk of harm does not exist, restrictions on the practice of an act should be minimized to maximize the public's freedom to access related services.

Given these circumstances, it is appropriate for the COO to reduce the current restrictions and enable opticians to delegate all or part of the authorized act of dispensing to a person who has the knowledge, skill and judgment to perform the act, within established guidelines set by the College. This would free members to address other patient-centred obligations, and provide increased convenience and access to service for patients and clients. HPRAC recommends:

That the College of Opticians of Ontario make a regulation, subject to the approval of the Lieutenant Governor in Council, permitting members to delegate the authorized act as set out in section 4 of the *Opticianry Act, 1991* subject to appropriate terms and conditions.

The *RHPA* enables the Minister to require a College Council to "make, amend or revoke a regulation under a health profession Act or the *Drug and Pharmacies Regulation Act*"[7] and if the Council does not comply within sixty days, the Lieutenant Governor in Council, on the Minister's recommendation, may do so.[8] HPRAC recommends:

That in the event the College of Opticians of Ontario does not make the regulation, pursuant to section 5 (1) (c) of the *RHPA*, and pursuant to

---

[5] http://www.collegeoptom.on.ca/Del%20%20assign%20w%20edits%20Jan%209-05.pdf
[6] O. Reg 828/93 amended to O. Reg 216/94
[7] Section 5 (1) (c), *RHPA*
[8] Section 5 (3), *RHPA*

O. Reg 828/93 amended to O. Reg 216/94, Section 1.4, the Minister direct the College to make a regulation permitting members to delegate the authorized act as set out in section 4 of the *Opticianry Act, 1991* subject to appropriate terms and conditions.

7. Refractometry

7.1 Refractometry Explained

Refractometry describes the act of measuring the refractive error of the eye for the purposes of a sight test. It includes the determination of values to describe the power of the lenses required to focus light on a patient's retina. Refractions are used in combination with ocular health and binocular assessments to diagnose the cause of vision impairments and, if necessary, the most appropriate eyewear prescription.

7.2 Standards of Practice

Refractometry is regularly performed by optometrists, ophthalmologists, and some physicians as one part of the ocular visual test for patients. The regulatory colleges for these professions are responsible for standards of practice of their members.

7.3 Minister's 2001 Directive

Prior to 2001, Ontario's opticians did perform refractions. Results were often provided to optometrists or ophthalmologists for the purposes of authorizing eye wear prescriptions. However, concern was raised that some opticians were dispensing eye wear based on the results of the refraction they performed. HPRAC interpreted this to mean that opticians were, in fact, prescribing and therefore exceeding their scope of practice. Moreover, it was argued that this constituted unsafe practice. On February 7, 2001, the Minister of Health and Long-Term Care directed the College of Opticians to require its members to cease performing refractions.[9]

> Most importantly, because HPRAC expressed concern that the per formance of refractometry by opticians could circumvent the public safety measures within the *Regulated Health Professions Act, 1991 ("RHPA")* and because we feel that HPRAC's advice is in keeping with the public interest mandate underlying the *RHPA*, I am requesting that the College immediately take appropriate steps to prohibit the performance of refractometry and the altering of a prescription by its members.[10]

---

[9] Letter to the Executive Council of the College of Opticianry of Ontario from Minister Elizabeth Witmer, February 7, 2001. In it, she directs Council to "immediately inform its members that refractometry is not part of the Scope of Practice under the *Opticianry Act, 1991*." Further she instructs that the College immediately take appropriate steps to prohibit the performance of refractometry and the altering of a prescription by its members." The College complied by formalizing a new standard of practice that was issued to members on March 9, 2001.

[10] Letter from Minister Witmer to Jean Warbucks, President College of Opticians of Ontario, February 7, 2001.

Since 2001, opticians have respected the prohibition placed on the performance of refractometry. They have, however, continued to press for an expanded role which includes refractometry.

> "Ontario opticians wish to provide refractometry services for Ontario consumers... As well, they wish to use the results derived from the refractometry service to make eyewear."[11]
>
> Ontario Opticians Association

8. Options

To help answer the question "Should refractometry be in the scope of practice of opticians and, if so, for what purpose?", HPRAC examined a number of options, including:

- Stand-alone refractometry which would allow opticians to perform the refractive portion of the eye exam without acting on the results;
- Refraction, with prescribing, whereby opticians would be allowed to perform the refractive portion of an eye exam and then prescribe eye wear based on these results alone; and
- Refraction, whereby opticians would be able to conduct refractometry tests, but would work in collaboration with a professional who has the authority to prescribe under the *RHPA* and who would use the results of the refractometry test as part of a full eye examination.

All but the third option have significant risks of harm. These are discussed below.

9. Factors Informing HPRAC's Recommendation

9.1 Risk of Harm

Results of consultations and document analyses indicate that there is no risk of harm in performing stand alone refractometry. It is a simple test that is mechanical in nature.

The risk of harm arises from what is done with the results. If the results are incorporated into a full eye examination, along with other assessment tools, it can inform a diagnosis, and may lead to a prescription for corrective vision devices.

Relying solely on the results of a refraction test substantially increases risk of harm to patients since opticians would be assessing the vision and eye wear needs of the patient based on limited information. The likelihood of failure to detect disease, failure to refer to a qualified professional, or failure to assess eye conditions correctly would be increased.

The Advisory Council has serious concerns that patients may not understand that the health of their eyes is not being fully monitored and assessed. This could result in patients neglecting to visit a professional who is trained to prescribe treatment for eye conditions, diseases and illnesses. Patients may simply assume that their eyes are healthy since the optician has not mentioned any underlying health issues.

---

[11] Submission to HPRAC by the Ontario Opticians Association and the Opticians Association of Canada, April 2005, pg 7.

9.2 Two-Tier Regulation

In the course of HPRAC's review, the College of Opticians of Ontario proposed strategies to mitigate risks associated with missed diagnoses by limiting optician prescriptions based on refraction test results to a portion of the population believed to be low risk for underlying eye health issues. Those qualifying for refraction tests would be screened in order to exclude people in high-risk groups or where underlying health issues were disclosed. Excluded groups would include:[12]

- Those younger than 19 and older than 65;
- Those who have never worn glasses previously;
- Those who have not seen an optometrist in the last year;
- Those known to have glaucoma;
- Those known to have strabismus;
- Those known to have diabetes;
- Those whose visual acuity cannot be corrected to 20/40 in each eye;
- Those with a prescription less than -9.00 dioptres;
- Those with a change in refraction greater than 2.00 dioptres within a specified timeframe;
- Those with visual anomalies, and
- Those whose preliminary evaluation does not indicate good eye health.

The COO proposes to develop screening protocols and train its members on how to apply them. Members would be taught to promote client awareness about "automated sight testing": what it is, its limits in comparison to a healthy eye exam, and the importance of regular vision care appointments with an optometrist or physician. COO members would also need to obtain informed consent from "qualified" clients. This could involve completion of a document, signed by both the optician and patient, that assesses the patient's eligibility for refraction. Although the proposed COO document states that it is not a waiver, its legal status as "consent to treatment" absolving the optician of responsibility for the patient or client's decision, is untested.

9.3 Access and Need

Approximately 3,000,000 people in Ontario visit an optometrist each year.[13] In 2004, the average number of optometrists per 100,000 population across Ontario was 10.85. Comparatively, there were 15.03 opticians per 100,000 population.[14] The rate of increase of active registered optometrists, as reported in the Health Personnel Database (HPDB) has been greater than the population growth rate.[15]

---

[12] Specific illnesses, symptoms and procedures will also make individuals ineligible for refractions unless they are already under a physician's supervision of their condition and the physician approves of the optician doing the refraction. Submission to HPRAC by the College of Opticianry of Ontario, 2005, pg 40.

[13] Ontario Association of Optometrists. Backgrounder: Optometry in Ontario – The State of Funding for OHIP Insured Services, 2004.

[14] College of Opticians of Ontario, January, 2003.

Public opinion studies, which formed part of the literature review, indicate that patients do not feel restricted in their access to optometrists and eye wear prescriptions. In fact, only one per cent of recently examined Canadians in a 1997 study had difficulty obtaining an appointment.[16] Focus group consultations conducted as part of this review confirmed that access to eye care professionals in most areas of Ontario is not an issue. Where there are shortages of opticians or optometrists, the population is not large enough to support their full-time business. In some communities, services provided by optometrists are offered on a weekly or regularly scheduled basis.

While all areas of the province were not included in the focus group consultation, there were no indications that people could not receive care in a reasonable period of time from a professional who was appropriately trained.

9.4 Public Interest

There are significant differences in proficiency among opticians, optometrists and ophthalmologists. Optician training programs are not intended to, and do not prepare opticians to identify and determine the underlying causes of eye illnesses, diseases and conditions in patients.

HPRAC does not believe that it would serve the public interest to endorse a change in health regulation that encourages the public to rely on opticians as their primary eye care provider.

Members of the College of Opticians should not be authorized to dispense eye wear solely on the basis of a refraction test. However, linking an optician's ability to perform refraction with a professional who is authorized to prescribe mitigates the risks associated with stand-alone refractometry. It ensures that the consumer will obtain a full examination from a qualified optometrist, ophthalmologist, or family physician. It also ensures that all relevant health information will be considered in the writing of the prescription.

9.5 Summarizing the Case for Collaborative Practice

The Advisory Council finds that:

- There is no risk in performing the refraction test itself;
- Refractometry is a useful part of a complete ocular exam that includes an eye health assessment; and
- The use of refractometry as the sole basis for dispensing eye wear carries a significant risk of harm which is increased for certain demographic groups.

---

[15] Canadian Institute for Health Information, Health Personnel Trends in Canada, 1993-2002, 2004: 133-136.

[16] Federal, Provincial and Territorial Advisory Committee on Population Health, Statistical Report on the Health of Canadians, 1997: 103-105

Further, HPRAC is unable to support the COO's suggestion that opticians be able to prescribe eye wear for people aged 19 to 64 and who are relatively healthy, because:

- Implementation creates a two-tiered system that would be challenging to administer, difficult to oversee and confusing to the public;
- Patients may not disclose or be able to describe existing eye health conditions. The health consequences of incomplete or incorrect information may be substantial;
- Close to 15 per cent of optometric patients are unaware of an eye disease prior to a diagnosis. About half of these patients do not display symptoms prior to diagnosis. This poses a significant risk of harm to patients for whom early detection may prevent substantial eye damage; and
- There is increased risk of misjudging the cause of blurred vision as a refractive error when it can be the sign of other more serious vision conditions or chronic conditions such as thyroid disease or diabetes.

The Advisory Council concludes that there would be an increased risk to patients who relied on opticians to provide reassurance about the health of their eyes, even if they had been informed that the assessment-by-refraction is not a full eye examination. Indeed, patients could be even more confused by COO's proposed client awareness measures.

Consequently, HPRAC concludes that qualified opticians should be permitted to perform refractometry only for the purpose of informing a comprehensive ocular assessment and in conjunction with members of other professions who are authorized to prescribe eye wear, including an optometrist or a physician. Members of the College of Opticians should not be authorized to dispense eye wear solely on the basis of a refraction test.

Therefore, HPRAC recommends:

That the Minister revoke the direction issued by Hon. Elizabeth Witmer to the College of Opticians of Ontario on February 7, 2001, and

That the Minister issue a new direction to the College of Opticians of Ontario requiring it to develop a standard of practice limiting the authority of members who perform refractometry to those circumstances where such refracting is undertaken in collaboration with an optometrist or a physician for the purpose of informing a comprehensive ocular assessment.

10. Transition

10.1 Setting Standards of Practice for Refractometry

The setting of practice standards and guidelines is a major part of the duty of self-governing professions under the *RHPA*. COO will necessarily develop and enforce standards of practice for its members who perform refraction tests in collaboration with a physician or optometrist. A direction from the Minister will provide additional authority for this and impose obligations on the College in this regard.

10.2 Collaboration among Professionals

Allowing Opticians to practice refractometry in conjunction with a professional who is authorized to prescribe eye wear enhances the need for opticians to work collaboratively with optometrists, physicians and ophthalmologists. Consequently, there needs to be concurrence, understanding and collaboration between the three regulatory colleges with responsibilities for eye health. The colleges of optometrists, physicians and surgeons, and opticians must work together to produce guidelines and define best practices for their members reflecting these changes. Standards of practice should clearly specify the relationship among professionals when opticians perform refractions in conjunction with care provided by a member of the College of Optometrists or the College of Physicians and Surgeons of Ontario.

10.3 Eliminating Barriers

Current conflict of interest regulations that disallow optometrists from associating with opticians must be addressed to facilitate this collaboration. The College of Optometrists is in the process of preparing a revised regulation to reduce these barriers between the professions, and is expected to forward it to the Minister for review following completion of a consultative process and Council scrutiny. A new regulation should take into account the ability of opticians to perform refractions as part of a complete eye examination performed by an optometrist.

11. Recommendations

HPRAC recommends to the Minister:

1. That dispensing subnormal vision devices, contact lenses, or eye glasses other than simple magnifiers should remain a controlled act under the *RHPA*;

2. That the College of Opticians of Ontario make a regulation, subject to the approval of the Lieutenant Governor in Council, permitting members to delegate the authorized act as set out in section 4 of the *Opticianry Act, 1991* subject to appropriate terms and conditions;

3. That in the event that the College of Opticians of Ontario does not make the regulation, pursuant to section 5 (1) (c) of the *RHPA*, and pursuant to O. Reg 828/93 amended to O. Reg 216/94, Section 1.4, the Minister direct the College to make a regulation permitting members to delegate the authorized act as set out in section 4 of the *Opticianry Act, 1991* subject to appropriate terms and conditions;

4. That members of the College of Opticians should not be authorized to dispense eye wear solely on the basis of a refraction test;

5. That the Minister revoke the direction issued by Hon. Elizabeth Witmer to the College of Opticians of Ontario on February 7, 2001, and

   That the Minister issue a new direction to the College of Opticians of Ontario requiring it to develop a standard of practice limiting the authority of members who perform refractometry to those circumstances where such refracting is undertaken in collaboration with an optometrist or a physician for the purpose of informing a comprehensive ocular assessment;

6. That the College of Opticians of Ontario, the College of Optometrists of Ontario and the College of Physicians and Surgeons of Ontario should collaborate on standards of practice and guidelines for members of their respective professions.

7. That no changes are required to the *Opticianry Act, 1991* to give effect to these recommendations.

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel (416) 327–4300
Fax (416) 326–1571
www.gov.on.ca/health

Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

10^e étage, édifice Hepburn
80, rue Grosvenor
Toronto ON M7A 2C4
Tél (416) 327–4300
Téléc (416) 326–1571
www.gov.on.ca/health

Ontario

Ms. Barbara Sullivan
Chair
Health Professions Regulatory Advisory Council
55 St. Clair Avenue West Ste. 806
Toronto, ON M4V 2Y7

Barbara
Dear Ms. ~~Sullivan~~:

This letter asks the Health Professions Regulatory Advisory Council ("HPRAC") for advice on a number of issues respecting the regulation of health professions under the authority of the *Regulated Health Professions Act, 1991*, ("RHPA"), and to seek HPRAC's recommendations on certain referrals on a timely basis.

I recognize that, given the numerous and complex issues set out in this letter, it may not be possible for HPRAC to give advice on all these matters within the time allotted. Therefore, although the list below indicates my priorities at this time, please be aware that, from time to time, I may ask HPRAC to focus its attention on specific or new priorities that will be identified.

I look forward to receiving your advice in the form of an Advice Memorandum containing recommendations. Your advice is sought on the following matters, which are ranked in order of priority:

A. Previous HPRAC Reports and Advice

1) The currency of, and any additions to, recommendations made by the Council as part of the "5 year review" of the "*RHPA*" contained in its report *Adjusting the Balance*

2) The currency of, and any additions to, the Council's recommendations in relation to the Colleges' quality assurance programs and patient relations programs

…/2

-2-

Ms. Barbara Sullivan

3) The currency of, and any additions to, the Council's recommendations in relation to Colleges' complaints and discipline procedures

4) The currency of, and any additions to, the Council's recommendations in relation to optometrists prescribing therapeutic pharmaceutical agents

B. The Regulation of New Professions

1) Whether pharmacy technicians/assistants should be regulated under the RHPA, including what their scope of practice should be, what controlled acts, if any, they should be authorized to perform, and any protected titles

   Additionally, whether it is appropriate that pharmacy technicians be regulated under the *Pharmacy Act, 1991*

2) Whether homeopaths should be regulated under the RHPA, including what their scope of practice should be, what controlled acts, if any, they should be authorized to perform, and any protected titles, and whether it is appropriate that homeopaths be regulated under an existing profession specific act.

3) Whether kinesiologists should be regulated under the RHPA, including what their scope of practice should be, what controlled acts, if any, they should be authorized to perform, and any protected titles, and whether it is appropriate that kinesiologists be regulated under an existing profession specific act.

…/3

-3-

Ms. Barbara Sullivan

C. Psychotherapy

1) Whether psychotherapy should be an additional controlled act under the *RHPA* and if so, which regulated professions should have psychotherapy in their scopes of practice and how should standards be set and measured

2) Whether psychotherapists should be regulated under the *RHPA* as a profession, what their scope of practice should be and what controlled acts they should be authorized to perform as well as any protected titles, and whether it is appropriate that psychotherapists be regulated under an existing profession specific act.

D. Personal Support Workers

1) Review the range of work carried out by personal support workers and make initial recommendations on whether all or some part of this range would indicate that personal support workers should be considered for regulation under the RHPA.

E. Controlled Acts/Scope of Practice

1) Whether, in consideration of evidence of risk, the simple determination of a need for a hearing aid should be a controlled act, or whether determining the specifications for a hearing aid, based on a hearing test and an assessment of the physical aspects of the ear, should be the controlled act. Also, in consideration of evidence of risk, what aspects, if any, of hearing testing and dispensing of hearing aids should be controlled by the RHPA.

2) Whether there is a risk of harm in dispensing eye wear and what aspects, if any, of this activity need to be controlled by the RHPA, whether refractometry is within the scope of practice of opticianry, and how standards should be set and measured for both of these activities

F. New College Operations

1) Whether there are any impediments in the RHPA or the profession specific acts to a shared services business model for new professions for whom the financial demands of regulation are onerous, but where the public interest would be served by regulation eg. joint annual payment processes between new colleges or new college with an existing college

.../4

Ms. Barbara Sullivan

May I also ask you to keep me informed of any new or emerging issues that HPRAC becomes aware of.

I look forward to receiving HPRAC's Advice Memorandum, containing recommendations, by March 31, 2006.

Yours truly,

George Smitherman

George Smitherman
Minister

c. Presidents and Registrars of all Colleges under the RHPA
Presidents of associations representing health professionals regulated
- under the RHPA
Chair, Board of Directors of Drugless Therapy-Naturopathy
President, Ontario Association of Naturopathic Doctors

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-1571
www.health.gov.on.ca

Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

10e étage, édifice Hepburn
80, rue Grosvenor
Toronto ON M7A 2C4
Tél 416-327-4300
Téléc 416-326-1571
www.health.gov.on.ca

Ontario

Ms. Barbara Sullivan
Chair
Health Professsions Regulatory Advisory Council
55 St. Clair Avenue West Ste 806
Toronto, ON M4V 2Y7

Barbara
Dear Ms. Sullivan:

I would like to express my appreciation for the time and effort you and the members of the Health Professions Regulatory Advisory Council are devoting to meeting my request for advice on a number of issues regarding the regulation of health professionals. I know that your work has begun in earnest and that you have a full consultative process planned.

In my February letter to you, I mentioned that the issues were priorized and that I might be approaching the council to provide advice on new priorities. There is an additional priority which I am planning to refer to the council and to be fair to your council, knowing the workload that my earlier letter has created and that you are currently formulating your project plans, that I should inform you early of my intent.

Since this additional referral may affect the timelines for the work that I previously requested, Council may send its Advice Memorandum, containing recommendations for the February referral by April 30, 2006 rather than March 31, 2006.

…/2

Ms. Barbara Sullivan
Health Professions Regulatory Advisory Council
Page 2

Thank you again for your commitment to this endeavour.

Yours truly,

George Smitherman

George Smitherman
Minister

cc: Presidents and Registrars of all Colleges under the RHPA
Presidents of associations representing health professionals regulated under the RHPA
Chair, Board of Directors of Drugless Therapy-Naturopathy
President, Ontario Association of Naturopathic Doctors

Ministry of Health
and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Tel 416-327-4300
Fax 416-326-1571
www.health.gov.on.ca

Ministère de la Santé
et des Soins de longue durée

Bureau du ministre

10e étage, édifice Hepburn
80, rue Grosvenor
Toronto ON M7A 2C4
Tél 416-327-4300
Téléc 416-326-1571
www.health.gov.on.ca

Ontario

JAN 1 8 2006

Barbara Sullivan
Chair
Health Professions Regulatory
Advisory Council
55 St. Clair Ave. West, 8th Floor
Toronto, ON M4V 2X7

Barbara

Dear Ms Sullivan:

I understand that the Advisory Council's consultation sessions have been very well received and there is much information to consider. Please express my appreciation to Council members for their expertise and the time they are committing from their very busy schedules.

Several months ago, I indicated that there might be an additional issue that I would need to ask the Advisory Council to consider. In further discussions at that time with the Deputy Minister, we felt that we had already placed a heavy workload on the Advisory Council and wished it to concentrate its efforts on the February 2005 referral. I am pleased to hear that much has been accomplished and I now ask that you bring another issue before the Council.

Our government is committed to ensuring that users of non-traditional medicine and alternative approaches will have confidence in their safety. As you are aware, I recently introduced Bill 50 in the Legislature to regulate traditional Chinese medicine and to set out who would be allowed to perform acupuncture. The new *Traditional Chinese Medicine Act, 2005* and other amendments would provide for the use of the "Doctor" title by certain members of the new College of Traditional Chinese Medicine Practitioners of Ontario. To assist in the formulation of this unique certificate of registration, I ask that the Advisory Council provide me with advice regarding the educational requirements relating to "Doctor" title respecting certain members of the new College.

.../2

Page 2
Barbara Sullivan
Health Professions Regulatory Advisory Council

Please note that your advice should address what the new College Council should consider respecting educational requirements needed to achieve the "Doctor" title. We are also asking for your recommendations on how the standards for these educational requirements should be set and measured. It is important to keep in mind the different ways in which current traditional Chinese medicine practitioners may have acquired their knowledge, skills and judgement to practice on the one hand, and how, on the other, new applicants seeking registration in the profession and use of "Doctor" title should be prepared. I am asking that the Advisory Council take a comprehensive look at these issues, relating specifically to the practice of this new regulated health profession, with public interest and protection in mind.

I intend to share your advice with the new College for its consideration in setting the education standards for "Doctor" title applicants. Your recommendations will also be considered by the Ministry in its review of the College's regulation proposals.

I would ask that you continue with your current project plans in order to achieve the April 30, 2006 date for the issues in my February 2005 referral. The referral in my letter today is an important one and I would like your council to do its best to integrate this new project into its schedule but not to the detriment of meeting the April 30th date. I would therefore appreciate receiving advice on this new issue no later than September 30, 2006.

I want to take this opportunity to thank you for your leadership and look forward to the advice of Council.

Yours truly,

George Smitherman
Minister

cc: Presidents and Registrars of all Colleges under the RHPA
Presidents of associations representing health professionals regulated under RHPA
Chair, Board of Directors of Drugless Therapy-Naturopathy
President, Ontario Association of Naturopathic Doctors
Tony Wong, MPP Markham, Chair, MPP Consultation Group on Traditional Chinese Medicine and Acupuncture

RECOMMENDATIONS

Index

Page

Legislative Framework 301

Regulation of Optometrists 323

Regulation of Pharmacy Technicians 323

Regulation of Homeopathy and Naturopathy 324

Regulation of Kinesiology 329

Regulation of Psychotherapy 331

Regulation of Personal Support Workers 334

Regulation of Hearing Care 334

Regulation of Opticians 338

Legislative Framework

1. That Section 1 (1) of Schedule 2, Health Professions Procedural Code, should be amended by adding the following definition:

   "public outreach program" means a program to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991* and to enhance relations between and among the College, other Colleges, members, complainants and the public

2. That Section 1 (1) of Schedule 2, Health Professions Procedural Code, should be amended by deleting the definition of "quality assurance program" and substituting the following definition:

   "quality assurance program" means a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members

3. That section (3) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

   Objects of College

   3. (1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.

2. To develop, establish and maintain:

   (a) standards of qualification for persons to be issued certificates of registration,

   (b) programs and standards of practice to assure the quality of the practice of the profession,

   (c) standards of knowledge and skill, and programs to promote continuing evaluation, competence and improvement among the members and to address patient concerns and complaints, changes in practice environments, advances in technology, and other emerging issues,

   (d) standards of professional ethics for the members,

   (e) programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991.*

3. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.

4. To promote interprofessional collaboration with other Colleges as it relates to matters affecting two or more health professions, including, without limiting the generality of this, in connection with anything relating to,

   (a) standards of qualification, knowledge and skill for the performance of similar or shared controlled acts,

   (b) programs and standards of practice to assure the quality of the performance of the similar or shared controlled acts,

   (c) programs to promote continuous evaluation, competence and improvement in the performance of the similar or shared controlled acts, and to address patient concerns and complaints, changes in practice environments, advances in technology and other emerging issues, and

   (d) joint investigations of regulated health professionals practicing in multidisciplinary environments.

5. Any other objects relating to human health care that the Council considers desirable.

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest.

4. That section 10. (1) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

   10. (1) The College shall have the following committees:
   1. Executive Committee
   2. Registration Committee
   3. Inquiries, Complaints and Reports Committee
   4. Discipline Committee
   5. Fitness to Practise Committee
   6. Quality Committee

5. That section 11. (1) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

   Each committee named in subsection 10 (1) shall regularly monitor and evaluate their processes and outcomes and shall annually submit a report of its activities to the Council in the form that the Council specifies.

6. That section 11. (2) of Schedule 2, Health Professions Procedural Code should be repealed.

7. That section 15 (2) of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

   has doubts, on reasonable grounds based on the applicant's past and present conduct, that the applicant will practice his or her health profession in accordance with the law, or with decency, integrity and honesty.

8. That section 80 of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

   (2) The quality assurance program shall include the following components:

   (a) entry to practise requirements,

   (b) standards of practice,

   (c) continuing education and professional development to promote continuing competence among the members and to address changes in practice environments, clinical standards, advances in technology and other emerging issues,

(d) self, peer and practice assessments,

(e) monitoring of members' participation in, and compliance with, the quality assurance program,

(f) evaluation or monitoring of data respecting complaints and reports, assessment and remediation processes and competence requirements to promote systemic improvement,

(g) interprofessional collaboration concerning the provision of quality care, continuous improvement in care and patient safety, or any matter described in clauses (a) to (g) as it affects the performance of similar or shared controlled acts.

9. That Sections 83 (3) of Schedule 2, Health Professions Procedural Code, should be repealed and the following substituted:

Referrals to Inquiries, Complaints and Reports Committee

(3) If the Quality Committee is of the opinion, based on an assessment, that a member may have committed an act of professional misconduct or may be incompetent or incapacitated, the Committee may disclose the name of the member and allegations against the member to the Inquiries, Complaints and Reports Committee.

10. That Sections 83.1 of Schedule 2, Health Professions Procedural Code, should be amended by adding the following subsection:

Orders by Quality Committee

(9) The Quality Committee may do any one or more of the following:

1. Require the member to participate in a specified continuing education or remediation program or a self, peer or practice assessment.
2. Monitor the member's progress in the specified program or assessment and reconsider the member's practice upon its completion.
3. Refer the member to the Inquiry, Complaints and Reports Committee for a failure to co-operate with the Quality Committee or any assessor it appoints or to participate in the quality assurance program or a specified program or assessment.

11. That Sections 84 and 85 of Schedule 2, Health Professions Procedural Code, should be repealed and the following substituted:

84. (1) The College shall have a public outreach program.

(2) The public outreach program shall include the following components:

(a) programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*,

(b) measures to enhance relations between and among the College, other Colleges, members, complainants and the public, including without limitation,

vii. notices to complainants and members,

viii. employer and facility relations,

ix. media relations,

x. public register, public hearings and Internet publications,

xi. reports to the Minister and the Health Professions Regulatory Advisory Council,

xii. interprofessional collaboration with other Colleges,

(c) measures for preventing or dealing with sexual abuse of patients.

(3) The measures for preventing or dealing with sexual abuse of patients must include,

(a) educational requirements for members;

(b) guidelines for the conduct of members with their patients;

(c) training for the College's staff; and

(d) the provision of information to the public.

(4) The Council shall give the Health Professions Regulatory Advisory Council a written report describing the public outreach program and, when changes are made to the program, a written report describing the changes.

85. Each Committee of the College shall advise the Council with respect to the public outreach program.

12. That Section 85.7 (3) of Schedule 2, Health Professions Procedural Code, should be repealed.

13. That wherever the words "Complaints Committee" appear in the *RHPA* or in the Health Professions Procedural Code, they should be replaced by the words "Inquiries, Complaints and Reports Committee", and that wherever the words "Quality Assurance Committee" appear in the *RHPA* or in the Health Professions Procedural Code they should be replaced by the words "Quality Committee".

14. That section 6 of the *RHPA* should be repealed, and the following substituted:

(1) Each College shall provide to the Minister, within the time and in the form that the Minister specifies, the plans, reports, financial statements, including audited financial statements, and information that the Minister requires for the purposes of administering this Act or for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning.

(2) The Advisory Council shall report annually to the Minister on its activities and financial affairs.

(3) Each College shall collect from its members, and each member shall provide to the College, the information required to provide the reports to the Minister under subsection (1) and the reports to the Advisory Council under section 11.

(4) Each College shall publish on its website on the Internet general information including, but not limited to:

(g) its role, responsibilities, programs and processes;

(h) the scopes of practice of the health professions it governs;

(i) the use of titles by its members;

(j) what constitutes professional misconduct for its members;

(k) how to access the public portion of the register;

(l) any other general information that the Minister specifies.

(5) Each College shall publish on its website on the Internet, within the time and in the form that the Minister specifies, its audited financial statements and general and statistical information on its,

(a) registration reviews and hearings;

(b) complaints reviews and hearings;

(c) discipline hearings;

(d) fitness to practise assessments;

(e) quality assurance assessments;

(f) other programs and processes that the Minister specifies.

15. That Section 23 (3) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

> (3) A person may obtain, during normal business hours and on the College's website, the following information contained in the register:
>
> 1. Information described in clauses (2) (a), (b), (c), (d.1) and (d.2).
>
> 2. Information described in clause (2) (d) relating to a suspension that is in effect.
>
> 2.1 Information described in clause (2) (d.3) relating to a revocation or suspension that is in effect.
>
> 3. The results of every disciplinary and incapacity proceeding,
>
> i. in which a member's certificate of registration was revoked or suspended or had terms, conditions or limitations imposed on it, or
>
> ii. in which a member was required to pay a fine or attend to be reprimanded or in which an order was suspended if the results of the proceeding were directed to be included in the register by a panel of the Discipline or Fitness to Practise Committee.
>
> 3.1 For every disciplinary proceeding, completed at any time before the time the register was prepared or last updated, in which a member was found to have committed sexual abuse, as defined in clause 1 (3) (a) or (b), the results of the proceeding.
>
> 3.2 Information described in clause (2) (e.1) related to appeals of findings of the Discipline Committee.
>
> 4. Information designated as public in the by-laws.

16. That Section 23 (6) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

> (6) The Registrar shall provide to a person, upon the payment of a reasonable charge, a paper or electronic copy of any information in the register a person may obtain.

17. That Section 56 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

> Publication of Decisions
>
> (1) The College shall publish a panel's decision and its reasons, or a summary of its reasons, on its website as soon as the decision is released and in its annual report and may publish the decision and reasons or summary in any other publication of the College.

18. That Section 23 (2) of Schedule 2, the Health Professions Procedural Code should be amended by adding a new subsection as follows:

    a notation of every complaint and report filed with the College and the disposition of the complaint and report.

19. That section 25 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    Investigation of complaints and reports

    25. (1a) A complaint or report filed with the Inquiry, Complaints and Reports Committee regarding the conduct or actions of a member shall be investigated by College personnel at the direction of a panel selected by the chair of the Committee.

    (1b) The panel shall monitor the progress of the investigation, request additional information from the investigator when necessary, and consider the results of the investigation.

    (1c) Where a complaint or report concerns a service provided in a multidisciplinary environment, the investigator may conduct or participate in an investigation of the complaint or report together with one or more investigators from or appointed by other Colleges, and may share information with the other investigators for the purposes of the investigation.

20. That section 25 (2) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    (2) A panel shall be composed of at least three members of the Inquiries, Complaints and Reports Committee, at least one of whom shall be a person appointed by the Lieutenant Governor in Council.

21. That section 25 (4) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    (4) A complaint must be in writing or recorded on a tape, film disk or other medium before it can be considered by a panel.

22. That section 25 (5) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

    Notice to member

    (5) The panel shall give the member who is the subject of a complaint or report immediate notice of the complaint or report and of the provisions of subsection 26 (1).

    Notice to complainant or reporter

(6) The panel shall give the complainant or reporter who filed the complaint or report written notice of receipt of the complaint or report, a general explanation of the College's processes concerning the complaint or report and an expected date of disposition of the complaint or report.

23. That section 26 (2) of Schedule 2, the Health Professions Procedural Code be repealed and the following substituted:

Powers of panel

(2) A panel, after considering the results of an investigation of a complaint or report and the submissions of the member and after considering or making reasonable efforts to consider all records and documents it considers relevant to the complaint or report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or report.

2. Refer the member to the Fitness to Practise Committee for incapacity proceedings.

3. Require the member to appear before the panel to be cautioned.

4. Require the member to complete a specified continuing education or remediation program.

5. Require the member to undergo a physical, psychological, practice or other assessment.

6. Accept a voluntary undertaking of the member.

7. Facilitate and monitor the progress of any alternative resolution processes between the complainant and the member before referring an allegation to the Discipline Committee or a member to the Fitness to Practise Committee.

8. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws.

24. That section 26 (3) of Schedule 2, the Health Professions Procedural Code should be repealed.

25. That section 27 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Notice of decision

27. A panel shall give the complainant and the member who is the subject of the complaint,

(a) a copy of its decision;

(b) a copy of its reasons, if the panel decided to take no action with respect to a complaint or to do anything under paragraph 3, 4, 5, 6 or 8 of subsection 26 (2); and

(c) a notice advising the member and the complainant of any right to request a review they may have under subsection 29 (2).

26. That section 28 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

28. (1) A panel shall use its best efforts to dispose of a complaint within 150 days after the filing of the complaint in writing.

(2) If a panel has not disposed of a complaint within 150 days after the filing of the complaint, the panel shall provide the complainant and the member with written notice of and reasons for the delay in disposition, and an expected date of disposition.

(3) If a panel has not disposed of a complaint by the expected date of disposition described in subsection 28 (2), the panel shall provide the complainant and the member with written notice of the progress of the investigation of the complaint and the new expected date of disposition every thirty days until the complaint is disposed of.

27. That section 26 (1) (a) of the *RHPA* should be repealed.

28. That section 36 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

DISCIPLINE

Inquiries, Complaints and Reports Committee Referral

36. (1) The Inquiries, Complaints and Reports Committee may refer a specified allegation of a member's professional misconduct or incompetence to the Discipline Committee.

Allegations of sexual abuse

(2) In deciding whether or not to refer an allegation of the sexual abuse of a patient to the Discipline Committee, the Inquiries, Complaints and Reports Committee shall take into account any opinion, required under subsection 85.3 (5), as to whether or not the member who is the subject of the report is likely to sexually abuse patients in the future.

Idem

(3) The Inquiries, Complaints and Reports Committee shall refer a substantiated obligation of the sexual abuse of a patient of

the kind described in subparagraph i, ii, iii or iv of paragraph 2 of subsection 51(5) to the Discipline Committee.

29. That section 37 (1) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Interim suspension

37. (1) The Inquiries, Complaints and Reports Committee may, subject to subsection (5), make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if,

(a) an allegation is referred to the Discipline Committee; and

(b) it is of the opinion that the conduct of the member exposes or is likely to expose his or her patients to harm or injury.

30. That section 37 (5) of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Restrictions on orders

(5) No order shall be made under subsection (1) with respect to a member unless the member has been given,

(a) notice of the Inquiries, Complaints and Reports Committee's intention to make the order; and

(b) at least fourteen days to make written submissions to the Inquiries, Complaints and Reports Committee.

31. That section 57, Schedule 2, the Health Professions Procedural Code should be repealed.

32. That section 58 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Appointment of health assessor

58. (1) The Registrar may appoint one or more health assessors to determine whether a member is incapacitated if the Inquiries, Complaints and Reports Committee has received a written complaint or report about the member and has requested the Registrar to conduct a health assessment.

Notice to member

(2) The Inquiries, Complaints and Reports Committee shall give a member notice that it intends to request the appointment of a health assessor to inquire into whether the member is incapacitated before the Registrar makes the appointment.

33. That section 59 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Inquiries by health assessor

59. (1) A health assessor shall make inquiries the health assessor considers appropriate.

Physical or mental examinations

(2) If, after making inquiries, a health assessor has reasonable and probable grounds to believe that the member who is the subject of the assessment is incapacitated, the Inquiries, Complaints and Reports Committee may require the member to submit to physical or mental examinations conducted or ordered by a health professional specified by the health assessor and may, subject to section 63, make an order directing the Registrar to suspend the member's certificate of registration until he or she submits to the examinations.

34. That section 60 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Health assessor's report

60. A health assessor shall report to the Inquiries, Complaints and Reports Committee and shall give a copy of the report and a copy of any report on an examination required under subsection 59 (2) to the member who was the subject of the assessment.

35. That section 61 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Referral to Fitness to Practise Committee

61. After receiving the report of a health assessor, the Inquiries, Complaints and Reports Committee may refer the matter to the Fitness to Practise Committee.

36. That section 62 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Interim suspension

62. (1) The Inquiries, Complaints and Reports Committee may, subject to section 63, make an interim order directing the Registrar to suspend or impose terms, conditions or limitations on a member's certificate of registration if,

(a) it has referred a matter involving the member to the Fitness to Practise Committee; and

(b) it is of the opinion that the physical or mental state of the member exposes or is likely to expose his or her patients to harm or injury.

Procedure following interim suspension

(2) If an order is made under subsection (1) by the Inquiries, Complaints and Reports Committee in relation to a matter referred to the Fitness to Practise Committee,

(a) the College shall prosecute the matter expeditiously; and

(b) the Fitness to Practise Committee shall give precedence to the matter.

Duration of order

(3) An order under subsection (1) continues in force until the matter is disposed of by a panel of the Fitness to Practise Committee.

37. That section 63 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted.

Restrictions on orders

63. No order shall be made with respect to a member by the Inquiries, Complaints and Reports Committee under subsection 59 (2) or 62 (1) unless the member has been given,

(a) notice of the intention of the Committee to make the order;

(b) at least fourteen days to make written submissions to the Committee; and

(c) in the case of an order by the Committee under subsection 62 (1), a copy of the provisions of section 62.

38. That section 75 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Investigators

75. The Registrar may appoint one or more investigators to determine whether a member has committed an act of professional misconduct or is incompetent if,

(a) the Inquiries, Complaints and Reports Committee has received a report from the Quality Committee with respect to the member and has requested the Registrar to conduct an investigation; or

(b) the Inquiries, Complaints and Reports Committee has received a written complaint or report about the member and has requested the Registrar to conduct an investigation.

39. That section 79 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

Report of investigation

79. The Registrar shall report the results of an investigation to the Inquiries, Complaints and Reports Committee.

40. That a new definition of be alternate resolution be added to the Health Professions Procedural Code as follows:

"alternate resolution process" includes mediation, conciliation, negotiation or any other means of facilitating the resolution of issues in dispute.

41. That a new section be added to the Health Professions Procedural Code as follows:

Alternate Resolution

1. A panel of the Inquiries, Complaints and Reports Committee may direct a complainant and the member who is the subject of the complaint to participate in an alternate resolution process for the purposes of resolving the complaint or an issue arising from the complaint, unless the complaint relates to an allegation that the member has committed sexual abuse of the kind described in subparagraph i, ii, iii, iv or v of paragraph 2 of subsection 51 (5).

2. All settlements achieved by means of an alternate resolution process must be reviewed and approved by the panel.

3. If the panel approves of a settlement, it shall create a written record of the process conducted containing, at a minimum, a description of the settlement reached and the matters disclosed during the process, and shall place this record on the register maintained by the Registrar.

4. If a settlement cannot be reached using the alternate resolution process or if the Inquiries, Complaints and Reports Committee refuses to approve the settlement, the usual process of the Inquiries, Complaints and Reports Committee shall commence.

5. An alternate resolution process may only be used if,

   (a) the complainant and the member consent, on an informed and voluntary basis, to participate in the process,

   (b) the Inquiries, Complaints and Reports Committee has made written rules concerning use of the process [including rules on full and frank disclosure of all matters and comprehension by both the complainant and the member of the language used].

   (c) the rules provide that a person appointed to help resolve a matter by means of this process may be a member of the Inquiries, Complaints and Reports Committee or a person independent of the Committee; however, a member of the Committee who is so appointed shall not subsequently deal with the matter if it comes before the Committee unless the complainant and the member consent.

6. No person appointed to help resolve a matter by means of an alternate resolution process shall be compelled to give testimony or produce documents in a proceeding with respect to matters that come to his or her knowledge in the course of his or her assistance other than a proceeding under the *Regulated Health Professions Act*, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*.

7. No record, document or thing prepared for or statement given concerning an alternate resolution process is admissible in a proceeding other than a proceeding under the *Regulated Health Professions Act*, a health profession Act or the *Drug and Pharmacies Regulation Act* or a proceeding relating to an order under section 11.1 or 11.2 of the *Ontario Drug Benefit Act*.

42. That section 85.1 of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

    A member shall file a report in accordance with section 85.3 if the member has reasonable grounds, obtained in the course of practising the profession, to believe that another member of the same of different College has sexually abused a patient or has committed an act of professional misconduct or may be incompetent or incapacitated.

43. That section 85.2 of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

    A person who operates a facility where one or more members practise shall file a report in accordance with section 85.3 if the person has reasonable grounds, obtained in the course of practising the profession, to believe that a member who practises at the facility has sexually abused a patient or has committed an act of professional misconduct or may be incompetent or incapacitated.

44. That section 85.3 (1) of Schedule 2, Health Professions Procedural Code should be repealed, and the following substituted:

A report required under section 85.1, 85.2 or 85.5 must be filed in writing with the Inquiries, Complaints and Reports Committee of the College of the member who is the subject of the report.

45. That Section 85.3 (2) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Timing of report

(2) A report required under section 85.1, 85.2 or 85.5 must be filed within thirty days after the obligation to report arises unless, in the case of a report of sexual abuse, the person who is required to file the report has reasonable grounds to believe that the member will continue to sexually abuse the patient or will sexually abuse other patients or, in other cases, the person who is required to file the report has reasonable grounds to believe that the member is putting his or her patients at immediate risk of harm, in which case the report must be filed forthwith.

46. That Section 85.3 (3) of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Contents of report

(3) The report must contain,

(a) the name of the person filing the report;

(b) the name of the member who is the subject of the report;

(c) an explanation of the alleged sexual abuse, act of professional misconduct, incompetence, incapacity or revocation, suspension or imposition of restrictions on privileges or employment.

(d) if the grounds of the person filing the report are related to a particular patient of the member who is the subject of the report, the name of that patient, subject to subsection (4).

47. That Section 85.5 of Schedule 2, Health Professions Procedural Code should be repealed and the following substituted:

Reporting by employers, etc.

85.5 (1) A person who terminates the employment or revokes, suspends or imposes restrictions on the privileges or employment of a member or who dissolves a partnership, a health profession corporation or association with a member for reasons of professional misconduct, incompetence or incapacity shall file with the Inquiries, Complaints and Reports Committee within thirty days after the termination, revocation, suspension, imposition or dissolution a written report setting out the reasons.

Same

(2) If a person intended to terminate the employment of a member or to revoke the member's privileges for reasons of professional misconduct, incompetence or incapacity but the person did not do so because the member resigned or voluntarily relinquished his or her privileges, the person shall file with the Inquiries, Complaints and Reports Committee within thirty days after the resignation or relinquishment a written report setting out the reasons upon which the person had intended to act.

Application

(3) This section applies to every person, other than a patient, who employs or offers privileges to a member or associates in partnership or otherwise with a member for the purpose of offering health services.

48. That Section 85.6 of Schedule 2, Health Professions Procedural Code should be amended by adding the following subsection:

Co-operation with Inquiries, Complaints and Reports Committee

85.6 (b) Every person who files a report under section 85.1, 85.2, 85.4 or 85.5, and every person who may have relevant information about the member who is the subject of the report shall co-operate with the Inquiries, Complaints and Reports Committee and with any investigator it appoints and in particular shall,

(a) permit the investigator to enter and inspect the premises where the member practices;

(b) permit the investigator to inspect the member's records of the care of patients;

(c) give the Committee or the investigator the information in respect of the care of patients or in respect of the member's records of the care of patients the Committee or investigator requests in the form the Committee or investigator specifies; and

(d) confer with the Committee or the investigator if requested to do so by the Committee.

49. That section 1 of the *RHPA* should be amended by adding the following definition:

"bodily harm" means any harm, hurt or injury, whether physical, psychological or emotional, that interferes in a substantial way with the integrity, health or well-being of an individual;

50. That section 30 (1) of the *RHPA* should be repealed and the following substituted:

> No person, other than a member treating or advising within the scope of practice of his or her health profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably forseeable that serious bodily harm may result from the treatment or advice or from an omission from them.

51. That Sections 33 and 43(1)(d) of the *RHPA* should be repealed, and the following substituted:

> 34. (1) No person shall use the title "doctor", a variation or abbreviation or an equivalent in another language in the course of providing or offering to provide, in Ontario, health care to individuals.
>
> (2) Subsection (1) does not apply to a person who,
>
> (a) is a member of a College; and
>
> (b) holds an earned doctorate degree in the discipline in which the person is registered by the College.
>
> (3) In this section,
>
> "abbreviation" includes an abbreviation of a variation; and
>
> "earned doctorate degree" means a doctorate degree granted by an educational institution that is accredited or approved by a certifying body that is approved by the College.
>
> (4) No person shall, orally or in writing, use the title "doctor", a variation or abbreviation or an equivalent in another language, under subsection (2) without indicating the discipline in which the person holds the doctorate.

52. That section 11 (1) of the *Nursing Act, 1991* should be repealed and the following substituted:

> No person other than a member shall use the title "nurse", "registered nurse", "nurse practitioner" or "registered practical nurse", a variation or abbreviation or an equivalent in another language.

53. That section 11 (5) of the Nursing Act, 1991 should be repealed and the following substituted:

> No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a nurse, registered nurse, nurse practitioner or practical nurse or in a specialty of nursing.

54. It is the intention of HPRAC to conduct a further review and consultations on the use of titles in the profession of psychology, with a view to presenting recommendations to the Minister by October, 2006.

55. That a collaborative task force, including representatives from the Federation of Health Regulatory Colleges of Ontario, HPRAC and representatives of the Ministry of Health and Long-Term Care, jointly establish procedures that will

    (a) improve communication and information sharing so that all parties will have the information they need to carry out their responsibilities in the regulation approval process;

    (b) develop a revised template for a general guide to the submission of proposals for regulation that is readily understood and implementable by all colleges;

    (c) develop and execute a communications plan to ensure that both parties fully understand the process, and how to expedite approvals.

56. That the Ministry set accountability standards for its performance in the regulation process, including

    (a) timeliness for acknowledgement and response to regulation proposals;

    (b) ongoing communication with the proponent concerning the status of the proposal;

    (c) adoption of appropriate mechanisms to resolve outstanding issues with Colleges;

    (d) distribution of guidelines and principles respecting regulations;

    (e) processes for regulation approval when there are several Acts involved, and where regulations must be concurrent;

    (f) an internal and external evaluation mechanism to contribute to continuing quality improvement in its regulation activity.

57. That public appointees to college councils should be selected on the basis of relevant education and experience: they must have the necessary knowledge, ability, willingness and commitment to fulfill their responsibilities as public members.

58. That the government consider changes to its appointment process to increase the term of public appointments to college councils, or allow an "at pleasure" appointment to continue until the Lieutenant Governor in Council appoints a successor.

59. That the government consider whether the Minister ought to appoint public members to college councils in lieu of the Lieutenant Governor in Council.

60. That there be parity in the provision of funds for the education of all council members, whether appointed or elected, and that Ministry funding for training and orientation of public members be sufficient to

enable public appointees to avail themselves of training opportunities on the same basis as professional members of college councils.

61. That the government engage in a timely and thorough review of public appointee compensation leading to the enhancement of compensation provided to public appointees to Councils.

62. HPRAC proposes to develop a consultation program that will enable each profession to assess the validity and currency of its scope and authorized acts, and to report to the Minister with its recommendations.

63. That section 5 of the *RHPA* should be amended by adding the following subsection:

    (a) The Minister may require a Council to provide reports and information for the purposes of administering this Act or for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning.

    Collection of Information from Members

    (b) Each College shall collect from its members, and each member shall provide to the College, the information required to provide the reports to the Minister under subsection (1).

64. That a joint task force should be established to include the Ministry and representatives of the Federation of Health Regulatory Colleges of Ontario to develop consistent criteria for the collection of aggregated data that would be helpful in health human resources and service delivery planning.

65. HPRAC proposes to begin consultations that explore regulatory options for extending the role of nurses in the field of anaesthesiology and to make recommendations to the Minister as a priority.

66. HPRAC proposes to begin consultations that explore health professions regulatory options for extending the role of physiotherapy orthopaedic specialists and to make recommendations to the Minister as a priority.

67. HPRAC proposes to conduct a review of whether scopes of practice are current in the health professions' diagnostic and technological sectors and whether new classes within these professions are appropriate to meet current and future needs. Advice will be provided to the Minister following this assessment.

68. That section 71 of Schedule 2, the Health Professions Procedural Code should be repealed and the following substituted:

No stay of certain orders pending appeal

71. An order made by a panel of the Discipline Committee on the grounds of incompetence or because of a finding that a member has committed sexual abuse of the kind described in subparagraph i, ii, iii or iv of paragraph 2 of subsection 51 (5), or an order made by a panel of the Fitness to Practise Committee on the grounds of incapacity, directing the Registrar to revoke, suspend or impose terms, limitations or conditions on a member's certificate of registration, takes effect immediately even if an appeal of the order is made, and the Court may not grant a stay of the order until disposition of the appeal.

69. That the title "Appeal to Board" preceding Section 21 (1) of Schedule 2, the Health Professions Procedural Code be amended to read "Hearing or Review of Application by Board".

70. That section 36 of the *Regulated Health Professions Act, 1991* be repealed and the following substituted:

36. (1) A person employed, retained or appointed for the purpose of the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act* or a member of a Council or committee of a College shall not disclose any information that comes to his or her knowledge in the course of his or her duties.

(2) Subsection (1) does not prohibit,

(a) disclosure of information that is available to the public under this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, a regulation under any of those Acts, or the by-laws or rules of practice and procedure made by a College;

(b) disclosure required in connection with the administration of this Act, a health profession Act or the *Drug and Pharmacies Regulation Act*, a regulation under any of those Acts, or the by-laws or rules of practice and procedure made by a College, including, without limiting the generality of this, in connection with anything relating to the registration of members, complaints about members, allegations of members' incapacity, incompetence or acts of professional misconduct or the governing of the profession;

(c) disclosure to a body that governs a health profession in Ontario or in a jurisdiction other than Ontario;

(d) disclosure required for the administration of the *Drug Interchangeability and Dispensing Fee Act*, the *Healing Arts Radiation Protection Act*, the *Health Insurance Act*, the *Independent Health Facilities Act*, the *Laboratory and*

Specimen Collection Centre Licensing Act, the *Ontario Drug Benefit Act*, the *Controlled Drugs and Substances Act* (Canada) and the *Food and Drugs Act* (Canada);

(e) disclosure required for the purposes of managing, evaluating, monitoring, allocating resources to or planning for all or part of the health system, including the delivery of services and human health resources planning by the Minister;

(f) disclosure to a police officer to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;

(g) disclosure by a person or member to his or her counsel;

(h) disclosure with the written consent of all persons to whom the information relates; or

(i) disclosure to a prescribed entity if the purpose of the disclosure is to protect one or more individuals from harm;

(j) disclosure of an investigation of a member if the disclosure is in the public interest, and in circumstances where:

1. the member has made the investigation a matter of public record, or
2. criminal charges have been laid against the member in connection with the same issue as is being investigated.

71. That protocols surrounding verbal prescriptions should specifically be addressed, individually and jointly, by the Ontario College of Pharmacists and other regulatory colleges whose members are authorized to prescribe medications such as the College of Physicians and Surgeons of Ontario (CPSO); Royal College of Dental Surgeons of Ontario (RCDSO); College of Nurses of Ontario (CNO); and College of Midwives of Ontario (CMO).

72. HPRAC believes that further examination of the individual listing of drugs in regulations for non-physician health professions who are authorized to prescribe is warranted. We propose to undertake that examination and provide advice to the Minister by November, 2006.

73. HPRAC proposes to examine through a consultative program whether there is a need for change to ensure that college policies and guidelines can be current, reflect best practices and at the same time be legally binding. In the course of that review, HPRAC will identify options as appropriate, and prepare advice for consideration by the Minister.

Regulation of Optometrists

1. That Ontario optometrists be granted the authority to prescribe therapeutic pharmaceutical agents with the exception of anti-glaucoma medications.
2. That *The Optometry Act, 1991* be amended by adding the following to section 4(4): Prescribing drugs in the categories of drugs as prescribed by regulation.
3. That the Council of the College of Optometrists of Ontario make regulations, subject to approval of the Lieutenant Governor, and with prior review of the Minister, prescribing the categories of drugs to be prescribed.
4. That subsequent to any legislative change, and to support its successful implementation, the College of Optometry of Ontario:
    1. Establish new practice and proficiency standards and guidelines for its members;
    2. Establish educational upgrading and bridging programs for members;
    3. Impose "terms, conditions and limitations" on certificates of registration for those members who have not had appropriate training in prescribing until the requisite proficiency had been achieved; and
    4. Undertake with the College of Physicians and Surgeons of Ontario the development of joint guidelines respecting co-management of glaucoma patients, referrals and other matters relating to collaboration between the two professions.

Regulation of Pharmacy Technicians

1. That Pharmacy Technicians be regulated as a class within the College of Pharmacists of Ontario.
2. That the description of Authorized Acts by pharmacy technicians should be:

    > In the course of engaging in the practice of pharmacy, a member who is registered as a pharmacy technician in accordance with the regulations is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense, sell or compound a drug.
3. That registered pharmacy technicians be authorized to perform the dispensing and compounding of drugs, as defined in subsection 117(1) of the *Drug and Pharmacies Regulation Act*.
4. That the restricted titles in the *Pharmacy Act, 1991* be amended as follows:

    > No person other than a member shall use the title "apothecary", "druggist", "pharmacist", "pharmaceutical chemist", "registered

pharmacy technician", a variation or abbreviation or an equivalent in another language.

and with respect to representation of qualification, that:
No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a pharmacist, a registered pharmacy technician or in a specialty of pharmacy.

5. That the Ontario College of Pharmacists' Council be composed of a) at least nine and no more than sixteen persons who are members elected in accordance with the by-laws, including at least seven and no more than twelve persons elected from among members who are pharmacists, and at least two and no more than four persons elected from among members who are registered pharmacy technicians; b) at least ten and no more than fifteen non-professional persons appointed by the Lieutenant Governor in Council, and c) the dean of each faculty of pharmacy of the universities in Ontario.

6. That regulations under the *Pharmacy Act* specify that receiving verbal prescriptions is not approved for registered pharmacy technicians.

7. That the Minister issue a direction specifying that protocols surrounding verbal prescriptions should specifically be addressed, individually and jointly, by the Ontario College of Pharmacists and other regulatory colleges whose members are authorized to prescribe medications: College of Physicians and Surgeons of Ontario (CPSO); Royal College of Dental Surgeons of Ontario (RCDSO); College of Nurses of Ontario (CNO); and College of Midwives of Ontario (CMO).

8. That the College of Pharmacists of Ontario implement a strategic communications plan during the transition phase and at the entry of registered pharmacy technicians to practice.

Regulation of Homeopathy and Naturopathy

1. That homeopaths and naturopaths should be regulated under the *Regulated Health Professions Act, 1991*.

2. That a College of Naturopaths and Homeopaths of Ontario should be established.

3. That the Council of the College should be composed of (a) at least six and no more than nine persons who are members elected in accordance with the College's by-laws; (b) at least five and no more than eight persons appointed by the Lieutenant-Governor-in-Council who are not members of the College, another College or Council under the *RHPA*.

4. That the Council should have a President and Vice-President elected annually by Council from among its members.

5. That every member of the College who practices homeopathy and every member of the College who practices naturopathy or resides in Ontario and who is not in default of payment of the annual membership

fee should be entitled to vote in an election of members of the Council.

6. That the scope of practice for naturopathy should be:

    The practice of naturopathic medicine is the promotion of health, the assessment of the physical and mental condition of an individual, and the diagnosis, prevention and treatment of diseases, disorders and dysfunctions through the integrated use of natural therapies and natural medicines that promote the individual's inherent self-healing mechanisms.

7. That the scope of practice for homeopathy should be:

    The practice of Homeopathy is the assessment of body system disorders through homeopathic techniques and treatment using homeopathic remedies to promote, maintain or restore health.

8. That homeopaths should not be authorized to perform any controlled acts.

9. HPRAC recommends the following regarding controlled acts for the profession of naturopathy:

    - **Communicating a Diagnosis**

      That the controlled act of communicating a diagnosis be authorized to naturopaths subject to the limit that the diagnoses that can be communicated are those which:

        - are reached through considering the individual's history the findings of a comprehensive health examination, and where necessary, the results of laboratory tests and other investigations that the member is authorized to perform; and

        - are reached after complying with mandatory indicators for referral and/or consultation to be developed by the naturopathy profession's regulatory College.

    - **Procedure Below the Dermis**

      That naturopaths be authorized to performing a procedure on tissue below the dermis for the purposes of venipuncture, skin pricking and needle acupuncture.

    - **Moving the Joints of the Spine**

      That naturopaths be granted the controlled act of "moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust".

    - **Administering a Substance**

      That naturopaths be authorized to administer a substance by inhalation or injection as designated by regulation.

- **Putting an instrument, hand or finger into openings of the body**

  That naturopaths be authorized the controlled act of putting an instrument, hand or finger into openings of the body as follows:

  - beyond the opening of the urethra to obtain a sample for cultures

  - beyond the labia majora but not beyond the cervix

  - beyond the anal verge but not beyond the rectal-sigmoidal junction

- **Forms of Energy**

  That naturopaths be authorized the controlled act of applying or ordering the application of a form of energy as follows:

  > Ordering diagnostic ultrasound and other forms of energy used for diagnosticpurposes as designated by regulation.

- **Prescribing, dispensing, selling and/or compounding drugs and natural products**

  That naturopaths be authorized to prescribe, dispense, sell and/or compound drugs that are consistent with naturopathic practice, as prescribed in regulations.

- **Allergy Testing**

  That the allergy testing controlled act not be authorized to naturopaths.

10. That the use of the title "Registered Homeopath", a variation or abbreviation or equivalent in another language, should be restriced to members of the college.

11. That a person who is not a member of the college should not represent him or herself as a person who is qualified to practise homeopathy in Ontario.

12. The use of the title "Naturopathic Doctor", "Doctor of Naturopathic Medicine" and "naturopath" a variation or abbreviation or equivalent in another language, should be restricted to members of the college; and

13. That a person who is not a member of the college should not represent him or herself as a person who is qualified to practice naturopathy or naturopathic medicine in Ontario.

14. That the Lieutenant-Governor-in Council, on recommendation of the Minister, should appoint, for a period of three years, a Transitional Council for Homeopathy, a Chair and Vice-Chair.

15. That the Lieutenant-Governor-in Council, on recommendation of the Minister, should appoint, for a period of one year, a Transitional Council for Naturopathy, a Chair and Vice-Chair.

16. That the Transitional Council for Homeopathy should be composed of a Chair; a Vice-Chair; at least six and no more than nine persons who are currently unregulated practitioners of homeopathy; at least three persons who are nominated by the College of Physicians and Surgeons of Ontario, the College of Chiropractors of Ontario and the Ontario College of Pharmacists; and at least five and no more than eight persons who are not currently unregulated practitioners of homeopathy, members of a regulated College or Council under the *RHPA*.

17. That the Transitional Council for Naturopathy should be composed of a Chair; a Vice-Chair; at least six and no more than nine persons who are currently members registered with the Board of Directors of Drugless Therapy – Naturopathy; at least three persons who are nominated by the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists, and the College of Chiropractors of Ontario; and at least five and no more than eight persons who are not currently members registered with the Board of Directors of Drugless Therapy – Naturopathy, members of a regulated College or Council under the *RHPA*.

18. That the Transitional Council for Homeopathy and the Transitional Council for Naturopathy should together and immediately move to:

    a) Appoint a Registrar;

    b) Develop and implement complaints, investigations and discipline processes;

    c) Develop College by-laws, including by-laws respecting the election of members to Council;

    d) Develop advertising, conflict of interest, and record-keeping regulations;

    e) Develop administrative procedures; and

    f) Develop codes of ethics and professional conduct.

19. That the Transitional Council for Homeopathy and the Transitional Council's committees should have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

20. That the Transitional Council for Naturopathy and the Transitional Council's committees should have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

21. That the Transitional Council for Homeopathy and its employees and committees should have the authority to do anything that is necessary or advisable until the Council is established.

22. That the Transitional Council for Naturopathy and its employees and committees should have the authority to do anything that is necessary or advisable until the Council is established.

23. That upon appointment of its members, the Transitional Council for Homeopathy should move immediately to develop:

    a) A list of currently unregulated homeopaths, including the names and addresses of persons who practice homeopathy, their education and training, and billing practices, as well as the form of homeopathy that each practices;

    b) High minimum qualifications for the practice of homeopathy;

    c) The educational qualifications and equivalency standards to address the registration of currently unregulated practitioners of homeopathy;

    d) Classes of registration for the practice of homeopathy

    e) General standards of practice for homeopathy;

    f) Standards for mandatory consultation and referral;

    g) Quality assurance and continuing competence programs for the practice of homeopathy; and

    h) Any matter related to the regulation of homeopathy which the Transitional Council considers appropriate.

24. That upon appointment of its members, the Transitional Council for Naturopathy should move immediately to develop:

    a) A list, including the names and addresses, of persons who are currently registered with the Board of Directors of Drugless Therapy – Naturopathy, their education and training, and billing practices as well as the form of naturopathy that each practices;

    b) High minimum qualifications for the practice of naturopathy;

    c) The educational qualifications and equivalency standards to address the registration of currently regulated and unregulated practitioners of naturopathy;

    d) Classes of registration for the practice of naturopathy;

    e) General standards of practice for naturopathy;

f) Standards for mandatory consultation and referral;

g) Quality assurance and continuing competence programs for the profession of naturopathy; and

h) Any matter related to the regulation of naturopathy which the Transitional Council considers appropriate.

25. That subject to the approval of the Lieutenant-Governor-in-Council, and with prior review of the Minister, the Council of the College of Naturopaths and Homeopaths should be authorized to make regulations

    - Prescribing high minimum qualifications for the practice of homeopathy and for the practice of naturopathy;

    - Prescribing and governing the therapies involving the practiceof the profession of homeopathy and the profession of naturopathy and prohibiting other therapies;

    - Adding protected titles; and

    - Any matter relevant to the profession of homeopathy and/or the practice of homeopathy; and any matter relevant to the profession of naturopathy and/or the practice of naturopathy.

26. That the *Drugless Practitioners Act* should be repealed.

Regulation of Kinesiology

1. That kinesiologists be regulated under the *Regulated Health Professions Act, 1991.*

2. That a College of Kinesiologists of Ontario (Ordre des kinésiologues) be established.

3. That the scope of practice for kinesiology be defined as follows:
    the application of scientifically based principles to enhance the strength, endurance and mobility of individuals with or without functional limitations, and the administration of musculoskeletal, neurological, biomechanical, physiological, psychological and task-specific tests, assessments, and measures.

4. That the Council of the College of Kinesiologists be composed of at least seven and no more than nine persons who are members elected in accordance with the by-laws of the College; at least five and no more than seven persons appointed by the Lieutenant Governor in Council, and one person selected in accordance with the by-laws who is a member of the faculty of a kinesiology program of a university in Ontario.

5. That the council has a president and vice-president elected annually by council from among its members.

6. That every member who practices and resides in Ontario and who is not in default of payment of the annual membership fee be entitled to vote in an election of members of the Council.

7. That the use of the title "kinesiologist" be restricted to members of the College.

8. That a person who is not a member of the College may not hold him or herself out as a kinesiologist.

9. That the Lieutenant Governor in Council, on recommendation of the Minister, appoint, for a two-year duration, a Transitional Council and Chair.

10. That the Transitional Council be composed of at least five and no more than seven persons who are representatives of the Ontario Kinesiology Association and the Canadian Society for Exercise Physiology, and at least three and no more than five persons who are not members of these Associations or of a regulated College under the *RHPA*.

11. That the Transitional Council and its employees and committees have the authority to do anything that is necessary or advisable until the College Council is established.

12. That the Transitional Council have the authority to appoint a Registrar, and the Registrar and the Council's committees have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

13. That the Minister direct the Transitional Council to undertake certain functions, including but not limited to:

    i. Inquiring into and determining the qualifications and competencies, including the education and training, of persons holding themselves out as kinesiologists in Ontario;

    ii. Inquiring into and determining the nature of the practice engaged in by persons holding themselves out as kinesiologists in Ontario;

    iii. Identifying, specifying, and assigning a name to areas of practice, within the collective practice engaged in by persons holding themselves out as kinesiologists in Ontario;

    iv. Establishing criteria for a baccalaureate program in kinesiology in Ontario, including core competencies, and any qualifying examination;

- v. Establishing criteria for the registration of kinesiologists in Ontario;
- vi. Establishing a pre-registration prior learning assessment program for persons holding themselves out as kinesiologists;
- vii. Establishing a pre-registration qualifying and educational bridging program for persons holding themselves out as kinesiologists;
- viii. Developing standards of practice for each area of practice;
- ix. Establishing standards for mandatory consultation, referral and transfer of care;
- x. Establishing processes for the election of the Council and overseeing the election of the first Council.

Regulation of Psychotherapy

1. That psychotherapy and psychotherapists be regulated under the *Regulated Health Professions Act*.

2. That a College of Psychotherapists of Ontario (Ordre des psychothérapeutes de l'Ontario) should be established.

3. That an enforceable scope of practice of psychotherapy should be defined in the Act, and that the scope of practice should restrict the practice of psychotherapy to certain regulated professionals, and that an exemption for certain activities should be included as follows:

   (1) Psychotherapy is the provision of a psychological intervention or interventions, delivered through a therapeutic relationship, for the treatment of cognitive, emotional or behavioural disturbances.

   (2) No person other than a member in good standing of the College, the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who has met the qualifications specific to the practice of psychotherapy as established by their College shall engage at any time in any of the activities as set out in (1).

   (3) The Act does not apply to counsellors providing information, encouragement, advice or instruction about emotional, social, educational or spiritual matters.

   (4) Notwithstanding (3), treatment that goes beyond the bounds of counselling should not be exempted.

4. That the Council of the College should be composed of (a) at least six and no more than nine persons who are members elected in accordance with the College's by-laws; (b) at least five and no more than eight persons

appointed by the Lieutenant-Governor-in-Council who are not members of the College, another College or Council under the *RHPA*.

5. That the Council of the College should establish an Advisory Committee to include representatives of the College of Psychologists of Ontario, College of Physicians and Surgeons of Ontario, Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario.

6. That the Council should have a President and Vice-President elected annually by Council from among its members.

7. That every member of the College who practices psychotherapy or resides in Ontario and who is not in default of payment of the annual membership fee should be entitled to vote in an election of members of the Council.

8. That the use of the title "psychotherapist" should be restricted to members of the College and members of the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who are qualified to practice psychotherapy.

9. That a person who is not a member of the College, or a member of the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the Ontario College of Social Workers and Social Service Workers, and the College of Nurses of Ontario who practices psychotherapy should not represent him or herself as a person who is qualified to practice psychotherapy in Ontario.

10. That the Lieutenant-Governor-in-Council, on recommendation of the Minister, should appoint, for a period of three years, a Transitional Council, Chair and Vice-Chair.

11. That the Transitional Council should be composed of a Chair; a Vice-Chair; at least six and no more than nine persons who are currently unregulated practitioners of psychotherapy; at least four and no more than six persons who are nominated by the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Social Workers and Social Service Workers, and the College of Nurses of Ontario; and at least five and no more than eight persons who are not currently unregulated practitioners of psychotherapy or members of a regulated College or Council under the *RHPA*.

12. That the Transitional Council should have the authority to appoint a Registrar and the Registrar and the Council's committees should have the authority to accept and process applications for the issuance of certificates of registration, charge application fees and issue certificates of registration.

13. That the Transitional Council and its employees and committees should have the authority to do anything that is necessary or advisable until the Council is established.

14. That upon appointment of its members, the Transitional Council should move immediately to develop:

    (a) A list of currently unregulated psychotherapists including the names of persons who practice psychotherapy, their education and training, billing practices, as well as the form of psychotherapy that each registrant practices.

    (b) High minimum qualifications for the practice of psychotherapy.

    (c) General standards of practice for psychotherapy.

    (d) Quality assurance programs for psychotherapy.

    (e) The educational qualifications and equivalency standards to address the registration of currently unregulated practitioners.

15. That the Minister of Health and Long-Term Care should issue a direction under section 5 (1) (d) of the *RHPA*, and the Minister of Community and Social Services should issue a direction under Section 11 of the *Social Work and Social Service Workers Act*, requiring the College of Psychologists of Ontario, the College of Physicians and Surgeons of Ontario, the College of Social Workers and Social Service Workers and the College of Nurses of Ontario to establish high minimum qualifications and general standards for the practice of psychotherapy in their professions.

16. That where one or more of those Colleges, in the opinion of the Ministers, fails to establish the qualifications and the necessary mechanisms to implement and enforce these qualifications and standards within the time specified by the Ministers in their directives, the qualifications established by the College of Psychotherapists should be deemed to apply.

17. That subject to the approval of the Lieutenant-Governor-in-Council, and with prior review of the Minister, the Council of the College of Psychotherapy of Ontario should be authorized to make regulations

    - Prescribing high minimum qualifications for the practice of psychotherapy.

    - Prescribing and governing the therapies involving the practice of the profession and prohibiting other therapies.

    - Exempting modalities that do not constitute the practice of psychotherapy.

    - Adding protected titles.

    - Any matter relevant to the profession of psychotherapist and/or the practice of psychotherapy.

18. That complementary amendments should be made to the *Nursing Act, 1991*, *Medicine Act,1991*, *Psychology Act,1991* and *Social Workers and Social Service Workers Act, 1998*.

Regulation of Personal Support Workers

1. That there should be no change to Section 29 (1) (e) of the *RHPA* that excepts individuals "assisting a person with his or her routine activities of living and the act is a controlled act set out in paragraph 5 or 6 of subsection 27 (2)."

2. HPRAC has completed the initial phase of work in response to the Minister's request for advice, and will offer final recommendations in September, 2006.

Regulation of Hearing Care

1. That it is not necessary to further define the controlled act of "prescribing a hearing aid for a hearing impaired person" in section 27 (2) 10 of the *Regulated Health Professions Act, 1991.*

2. That audiological assessment and communicating the results; communicating an audiologic diagnosis; hearing testing; inserting air, gas, or water under pressure, applying energy in the form of high sound pressure levels, inserting or removing instruments, devices, fingers or other objects into or from the ear canal; or performing cerumen management should not be made controlled acts under the *Regulated Health Professions Act, 1991.*

3. That Section 27 (2) 10. of the *Regulated Health Professions Act* should be repealed, and the following substituted:

   10. Prescribing or dispensing a hearing aid for a hearing impaired person.

4. That hearing instrument practitioners should be regulated as a profession under the *Regulated Health Professions Act, 1991.*

5. That the name of the *Audiology and Speech-Language Pathology Act, 1991* should be changed to the "Hearing and Speech-Language Professionals Act".

6. That the definition of "College" in Section 1 and Section 2 (2) of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed, and the following substituted:

   "College" means the College of Hearing and Speech-Language Professionals of Ontario ("ordre")

7. That the definition of "profession" in Section 1 and Section 2 (2) of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

   "profession" means the professions of audiology, speech-language pathology and hearing instrument practitioners

8. That a new definition of "by-laws" should be added to Section 2 (2) of the *Audiology and Speech-Language Pathology Act, 1991* as follows:

"by-laws" means the by-laws under this Act.

9. That Section 3 of the *Audiology and Speech-Language Pathology Act, 1991* should be amended by adding the following subsection:

    The practice of hearing instrument practitioners is the testing of hearing and the fitting and dispensing of hearing aids.

10. That Section 4 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed, and the following substituted:

    (1) In the course of engaging in the practice of audiology, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to prescribe or dispense a hearing aid for a hearing impaired person.

    (2) In the course of engaging in hearing instrument practice, a member is authorized, subject to the terms, conditions and limitations imposed on his or her certificate of registration, to dispense a hearing aid for a hearing impaired person.

11. That Section 5 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    The College is established under the name College of Hearing and Speech-Language Professionals of Ontario in English and Ordre des professionnels de l'audition et de l'orthophonie de l'Ontario in French.

12. That Section 6 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) The Council shall be composed of,

    (a) at least eight and no more than nine persons who are members elected in accordance with the by-laws;
    (b) at least six and no more than seven persons appointed by the Lieutenant-Governor-in-Council who are not,
        (i) members,
        (ii) members of a College as defined in the *Regulated Health Professions Act, 1991*, or
        (iii) members of a Council as defined in the *Regulated Health Professions Act, 1991*; and
    (c) three persons selected, in accordance with a by-law made under section 11, from among members who are members of a faculty of audiology or speech-language pathology of a university in Ontario or of a hearing instrument specialist program of a community college in Ontario.

    Who can vote in elections

    (2) Subject to the by-laws, every member who practises or resides in Ontario and who is not in default of payment of the annual

membership fee is entitled to vote in an election of members of the Council.

13. That Section 8 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) No person other than a member shall use the titles "audiologist", "speech-language pathologist", "speech therapist", "hearing instrument practitioner" or "hearing instrument specialist", a variation or abbreviation or an equivalent in another language.

    Representations of qualification

    (2) No person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as an audiologist, a hearing instrument practitioner, a hearing instrument specialist or a speech-language pathologist or in a specialty of audiology, speech-language pathology or a hearing instrument practice.

    Definition

    (3) In this section
    "abbreviation" includes an abbreviation of a variation.

14. That Section 11 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) The Council may make by-laws respecting the qualifications, selection and terms of office of Council members who are selected.

    (2) The by-laws shall provide for equal representation of audiologists, speech language pathologists and hearing instrument practitioners.

    (3) The Council shall make by-laws establishing three committees, each committee to be composed exclusively of members of one profession and lay members with the authority, subject to approval by Council, to establish rules, standards of practice and guidelines on matters of exclusive application to that profession in accordance with subject matter and criteria established by Council.

15. That Section 12 of the *Audiology and Speech-Language Pathology Act, 1991* should be repealed and the following substituted:

    (1) The College of Audiologists and Speech Language Pathologists of Ontario shall continue in force until section 5 is proclaimed.

    (2) The Lieutenant-Governor-in-Council, on recommendation of the Minister of Health and Long-Term Care, shall appoint for a period of two years, a Transitional Council, a Chair and Vice-Chair.

    (3) The Transitional Council shall be composed of a Chair; a Vice-Chair; at least two representatives nominated by the Council of the College of Audiologists and Speech-Language

Pathologists; at least two representatives nominated by the Association of Hearing Instrument Practitioners; one representative of a faculty of a hearing instrument specialist program of a community college in Ontario, and at least three and no more than four persons who are not members of the College of Audiologists and Speech-Language Pathologists.

Powers of Transitional Council

(4) After (date) but before this Act comes into force, the Transitional Council and its employees and committees may do anything that is necessary or advisable for the coming into force of this Act and that the Council and its employees and committees could do under this Act if it were in force.

Idem

(5) Without limiting the generality of subsection (3) the Transitional Council may appoint a Registrar and the Registrar and the Council's committees may accept and process applications for the issue of certificates of registration, charge application fees, and issue certificates of registration.

(6) Upon appointment of its members, the Transitional Council shall move immediately to:

1. Develop a list of practitioners who identify themselves as hearing instrument practitioners (including dispensers and specialists).
2. Identify a core body of knowledge common to hearing instrument practitioners.
3. Develop educational qualifications and equivalencies for registration.
4. Direct the registrar to register those applicants who meet the qualifications for registration, and identify any terms, limits or conditions that should be attached to the registration of an applicant.
5. Establish standards of practice for hearing instrument practitioners.
6. Develop quality programs for hearing instrument practitioners.
7. Develop communications programs to provide information to hearing instrument practitioners, academic institutions, other professions and members of the public.

Powers of Minister

(7) The Minister may:

(a) review the Transitional Council's activities and require the Transitional Council to provide reports and information.
(b) require the Transitional Council to make, amend or revoke a regulation under this Act.
(c) require the Transitional Council to do anything that, in the opinion of the Minister, is necessary or advisable to carry out the intent of this Act and the *Regulated Health Professions Act, 1991.*

Transitional Council to comply with Minister's request

(8) If the Minister requires the Transitional Council to do anything under subsection (7), the Transitional Council shall, within the time and in the manner specified by the Minister, comply with the requirement and submit a report.

Regulations

(9) If the Minister requires the Transitional Council to make, amend or revoke a regulation under clause (7) (b) and the Transitional Council does not do so within sixty days, the Lieutenant-Governor-in-Council may make, amend or revoke the regulation.

Idem

(10) Subsection (8) does not give the Lieutenant-Governor-in-Council authority to do anything that the Transitional Council does not have authority to do.

Expenses

(11) The Minister may pay the Transitional Council for expenses incurred in complying with a requirement under subsection (6).

Regulation of Opticians

1. That dispensing subnormal vision devices, contact lenses, or eye glasses other than simple magnifiers should remain a controlled act under the *RHPA*;

2. That the College of Opticians of Ontario make a regulation, subject to the approval of the Lieutenant Governor in Council, permitting members to delegate the authorized act as set out in section 4 of the *Opticianry Act, 1991* subject to appropriate terms and conditions;

3. That in the event that the College of Opticians of Ontario does not make the regulation, pursuant to section 5 (1) (c) of the *RHPA*, and pursuant to O. Reg 828/93 amended to O. Reg 216/94, Section 1.4, the Minister direct the College to make a regulation permitting members to delegate the authorized act as set out in section 4 of the *Opticianry Act, 1991* subject to appropriate terms and conditions;

4. That members of the College of Opticians should not be authorized to dispense eye wear solely on the basis of a refraction test;

5. That the Minister revoke the direction issued by Hon. Elizabeth Witmer to the College of Opticians of Ontario on February 7, 2001, and

   That the Minister issue a new direction to the College of Opticians of Ontario requiring it to develop a standard of practice limiting the authority of members who perform refractometry to those circumstances where such refracting is undertaken in collaboration with an optometrist or a physician for the purpose of informing a comprehensive ocular assessment;

6. That the College of Opticians of Ontario, the College of Optometrists of Ontario and the College of Physicians and Surgeons of Ontario should collaborate on standards of practice and guidelines for members of their respective professions.

7. That no changes are required to the *Opticianry Act, 1991* to give effect to these recommendations.

ERRATA

Please replace Recommendation 23 on pages 41, 100 and 309 with the following:

23. That section 26 (2) of Schedule 2, the Health Professions Procedural Code be repealed and the following substituted:

Powers of panel

(2) A panel, after considering the results of an investigation of a complaint or report and the submissions of the member and after considering or making reasonable efforts to consider all records and documents it considers relevant to the complaint or report, may do any one or more of the following:

1. Refer a specified allegation of the member's professional misconduct or incompetence to the Discipline Committee if the allegation is related to the complaint or report.

2. Refer the member to the Fitness to Practise Committee for incapacity proceedings.

3. Require the member to appear before the panel to be cautioned.

4. Require the member to complete a specified continuing education or remediation program.

5. Require the member to undergo a physical, psychological, practice or other assessment.

6. Accept a voluntary undertaking of the member.

7. Monitor the progress of any measure required under paragraphs 4, 5 or 6.

8. Facilitate and monitor the progress of any alternative resolution processes between the complainant and the member before referring an allegation to the Discipline Committee or a member to the Fitness to Practise Committee.

9. Take action it considers appropriate that is not inconsistent with the health profession Act, this Code, the regulations or by-laws.

Health Professions Regulatory Advisory Council
55 St. Clair Avenue West
Suite 806, Box 18
Toronto, Ontario, Canada M4V 2Y7

Telephone: 416-326-1550
Toll-Free: 1-888-377-7746
Fax: 416-326-1549

Website: www.hprac.org
E-mail: HPRACWebMaster@moh.gov.on.ca

ISBN 1-4249-0446-3 (Print)
© Copyright Queens Printer for Ontario, 2006
2.5M 04/06
Disponible en français

Ontario